Association of Medical Consultants
AMC
Mumbai

The GRASP

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For Association of Medical Consultants, Mumbai

(For Private Circulation Only)

Editorial

Dr Kritika Doshi

Dear AMC Friends,

Greetings of the new year!

It is my proud privilege to bring to you this yearly edition of "The GRASP".

"Change is the nature of life but challenge is the future of life"

As you all know, pre-COVID, AMC used to publish and distribute a physical copy of the GRASP. Due to the lockdown and resultant travel restrictions, we switched to an E-GRASP. The pleasure of reading a physical book was lost and we received many requests to again publish physical copies. Due to the costs involved, it was decided to come out with an annual issue which would contain all the regular features and I am proud to present the first annual issue of The GRASP.

As I am writing this editorial, it is the last day of the Mahakumbh being held at Prayagraj- the whole world is looking to the enormous task of holding such a huge gathering safely and successfully. In the context of AI and advanced technology, it is ironical that crores of people have travelled to take the holy dip at the Triveni Sangam. This a reflection of our deep-rootedbeliefs in our history and culture. I am noticing a similar change in the healthcare professionals – there is an openness to incorporate our ancient healing sciences in daily practice. At our AMCON too, we had the Secretary General of the Indian Yoga Association Shri Subodh Tiwariji give a talk on the Fundamental Understanding of Yoga from a scientific perspective. Next speaker was Shri Gauranga Das, ISKCON GBC & Director, GEV who spoke on The 4 sutras of mental health!

In this issue, we have contributions from Dr Lalit Kapoor and Dr Suganthi Iyer on the medicolegal angles of practice. We have interesting articles by our members who have pursued their inner calling and dabbled in arts with success.

It has been my privilege to be the Editor for The GRASP for almost 7 years- I have enjoyed every issue that I have helped create and share with you. I thank all of you for your encouragement and support.

I am signing off now and I wish the next Editor all the best.

With Warm Regards,
Dr Kritika Doshi

From the Desk of the President

Dr Vivek Dwivedi
President,
Association of Medical Consultants, Mumbai

Dear Friends and Colleagues,

It is a great pleasure to connect with you through this edition of Grasp, the official magazine of the Association of Medical Consultants, Mumbai. As we move forward in our journey, I take this opportunity to express my gratitude to each one of you for your unwavering support and active participation in AMC's initiatives.

AMC has always been committed to the welfare of medical professionals. Whether it is through advocacy, knowledge-sharing, networking, or welfare schemes, our goal is to strengthen the medical fraternity and ensure that we all continue to grow together. We are constantly evolving to meet the challenges of our profession, and your involvement plays a crucial role in shaping our future.

Through Grasp, we aim to bring you valuable updates, expert insights, and important developments in the medical field. I encourage you to contribute, share your thoughts, and actively engage with the association. Let us continue to support each other, uphold ethical medical practices, and work towards a better and stronger AMC community.

I look forward to meeting you at our upcoming events and hope we continue to learn and grow together.

Warm regards,

Dr. Vivek Dwivedi
President, Association of Medical Consultants, Mumbai

Secretary's Report

Dr Vikrant Desai
Hon. Secretary
AMC Mumbai

It is with great pleasure that I present this report as the Secretary of our esteemed association. Serving as Secretary for a second term has been an immensely rewarding experience. The role demanded strong organizational skills, coordination with various stakeholders, and unwavering dedication to the association's vision. While the responsibilities were challenging, the support from my colleagues, senior members, and the executive committee made the journey fulfilling. This tenure has been both an honor and a responsibility, allowing me to contribute to the growth and success of our initiatives.

Doctors' Day Program, which was conducted with great enthusiasm and participation is the one which all of us look forward to . The overwhelming response from our members reaffirmed the significance of this occasion in fostering professional unity and appreciation.

Additionally, the AMCON Program was a resounding success, bringing together experts and practitioners for an enriching exchange of knowledge. The event covered diverse and critical aspects of medical practice as well as spiritual and personality development.

Throughout the term, we also organized multiple Continuing Medical Education (CME) Programs, ensuring that our members remained updated with the latest advancements in medicine.

I extend my heartfelt gratitude to all members for their cooperation and encouragement throughout this tenure. Your support has been instrumental in achieving our shared goals, and I look forward to give my best for the betterment of our association.

Dr. Vikrant Desai
Hon. Secretary : AMC Mumbai

OBITUARIES

30-Mar-2024
DR. RAGHUNANDAN TORSEKAR
DERMATOLOGIST
MULUND

01-Apr-2024
DR. BIPIN KAMDAR
ORTHOPAEDIC SURGEON
SANTACRUZ

06-Apr-2024
DR. SATISH UDARE
DERMATOLOGIST
NAVI MUMBAI

19-May-2024
DR. OMPRAKASH CHOKHANI
CARDIO VASCULAR THORACIC SURGEON
JOGESHWARI

07-Jun-2024
DR. MEGHALI BHATTACHARJEE
OPHTHALMOLOGIST
ANDHERI

27-Jun-2024
DR. ASHOK SHYAM AGARWAL
PAEDIATRICIAN AND NEONATOLOGIST
THANE

08-Jul-2024
DR. ASHOK VAIDYA
CLINICAL PHARMACOLOGY
KHAR

11-Aug-2024
DR. KEDARNATH CHAUBAL
ORTHOPAEDIC SURGEON
WORLI

12-Aug-2024
DR. NANDKISHOR VARMA
GENERAL SURGEON
ANDHERI

21-Aug-2024
DR. FRANCIS CANDES
PATHOLOGIST
BORIVALI

23-Aug-2024
DR. DINESH V. BHAGAT
GENERAL SURGEON
BORIVALI

06-Sep-2024
DR. HASMUKH PATEL
GENERAL SURGEON
GHATKOPAR

OBITUARIES

23-Sep-2024
DR. NARSING KUMTA
PAEDIATRIC
MALAD

24-Sep-2024
DR. HARIKESH BUCH
GENERAL SURGEON
KANDIVALI

11-Oct-2024
DR. V.N. SHRIKHANDE
GENERAL SURGEON
DADAR

05-Nov-2024
DR. PAWAN SUREKA
PAEDIATRICIAN
BORIVALI

20-Nov-2024
DR. SHYAMKANT RATNAPARKHI
PATHOLOGIST
SANTACRUZ

09-Dec-2024
DR. RAJESH KAKU
GENERAL SURGEON
MUMBAI

13-Dec-2024
DR. SURESH MEHTALIA
DIABETOLOGIST ENDOCRINOLOGIST
DADAR

20-Jan-2025
DR. PURUSHOTTAM MAHALE
GENERAL PHYSICIAN
KHAR

28-Jan-2025
DR. AMIT SHAH
ORTHOPAEDIC SURGEON
CHEMBUR

03-Dec-2024
DR. GURUMUKH SAINANI
GENERAL PHYSICIAN
MUMBAI

08-Dec-2024
DR. ISHTIAQ SHEKHANI
GENERAL SURGEON
ANDHERI

17-Dec-2024
DR. ANIL NIMA
ANAESTHESIOLOGIST
KANDIVALI

03-Jan-2025
DR. KAMLESH BET
ANAESTHESIOLOGIST
MALAD

07-Jan-2025
DR. JAYASHREE THAKORE
OPHTHALMOLOGIST
ANDHERI

AMC Health & Accident Scheme

Dear Colleagues,

Greetings from the Health and Accident Cell of the Association of Medical Consultants. We as doctors know best how important health is, and how important it is to get timely medical assistance. Getting the best possible treatment is becoming expensive today. While we and our near and dear ones are dealing with the medical crisis at hand it certainly helps that we do not have to worry about the hospital bills. Medical inflation is the word we hear every day in the media and television and believe us it is very real and very daunting.

Hence there is no debate on the need to have a health insurance policy to take care of this aspect. With so many policies in the market the question would definitely come to your mind-"Why should I take AMC Health and Accident scheme?"

The AMC H&A Scheme is not just a policy. It was a scheme designed by our pioneers in the policy as a scheme made by the members and for the members

Highlights Of The Policy

- Age of entry up to 79 years completed as compared to 60 years in most policies. No other policy in the market will permit entry beyond 60 years and maximum beyond 65 years -after complete medical check-up and if that too if you do not have a single medical condition. If you do get a policy after that age, it will exclude preexisting diseases. AMC allows you to claim preexisting diseases after the stipulated waiting period as per age band.
- No medical check-up or investigations needed to enter the policy
- You can increase your Capital sum insured (CSI) even after the onset of the preexisting ailment and even after having taken a claim for a major ailment such as cardiac, malignancy, renal disease etc. Here again you your eligibility for the higher sum insured that you take will become available to you after the stipulated waiting period.
- Floater policy was introduced in October 2023 based on the feedback and need of our group. The floater has been a big success. This year we introduced the Rs 25 Lac and Rs 30 Lac structure and a substantial number of members increased their CSI.

We as a committee feel that the earlier Individual policy also had its own plus points. We are at the moment negotiating with the Insurance companies to give us both the options- the earlier Individual &the recent Floater and give each member a choice. Your positive feedback will help us to make this happen.

- There is a personal touch and easy point of contact with the committee members. Claims are scrutinized and passed by the

H&A committee. There is a flexible condoning of delay in submitting claims.

- Sophisticated investigations are covered on an OPD basis.
- Copayment is restricted to 10% of claim after the age of 55 years irrespective of the number of claims in the year.
- Our cashless network is expanding and more hospitals are seeking empanelment with AMC health scheme
- We are always looking to pay all the new IRDA directed payables
  We are still amongst the first to pay
- Intravitreal injections (anti VGEF drugs)
- Mental health claims for indoor admission needing medical intervention
- Monoclonal antibodies and several other newer modalities of treatment
- We accept potability and many of our members will vouch that they come to us when they have an unsatisfactory claim experience Why wait for that? Join Now
- We have a team of highly supportive scheme advisors in every geographical area available to you throughout the year. They will explain all the policy details to you, help you enrol and pay your premium. The maximum support of our scheme advisors comes into play at the time of claim a lodging, following it up and claim settlement
- We have also added a professional touch to our policy by engaging the services of Marsh. Their inclusion has brought value addition to our services

Warm regards

AMC Health and Accident Committee

Dr. Smita Sharma	Chairman	Cell: 98200 46656
Dr. Jayesh Shah	Convenor	Cell: 98690 57414
Dr. Suhas Kate	Advisor	Cell: 98201 47041
Dr. Suresh Rao	Patron	Cell: 98200 25201
Dr. Ajay Hariani	Co Convener	Cell: 98202 88508
Dr. Sudhir Naik (Chairman - PI Cell)	Member	By Invitation
Dr. Nitin Rao	Member	Cell: 98200 22368
Dr. Deepak Vaidya	Member	Cell: 93225 11069

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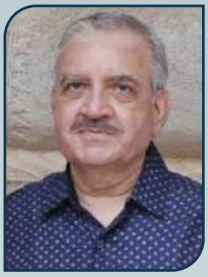
H & A Mobile (10 am to 6 pm)	8976870618
AMC H & A email id	supporthna@amcmumbai.org

For further details

- Please feel free to contact H&A committee
- AMC Office
- Please ask for copy of Health an Accident scheme brochure from office -soft copy will be
- emailed to you and physical copy can be sent to you by courier or with our scheme advisor
- The detailed list (name and contact numbers) of scheme advisors is available in the brochure



1: Concept Of Compensation

Dr Lalit Kapoor

The Indian Supreme Court awarded a record compensation payout for medical negligence that resulted in the death of a patient. In the case known as Dr Balram Prasad Vs Dr Kunal Saha and others, the patient who was a U.S resident, had died following development of drug-induced Toxic Epidermal Necrolysis (TEN).The doctors and the hospital were found to be guilty of negligence and a sum of Rs. 6, 08, 00550 + interest amounting to a total of over Rs 11 crores was awarded. There were also a few other recent cases where huge compensations were awarded by the courts : Krishna Kumar Vs State of Tamil Nadu –Rs 1,38,00,000 + 41.37 lakhs for medical expenses ; Nizam Institute Vs Prasanth Dhanaka –Rs. 1 crore + interest ; Dr Indu Sharma Vs Indraprastha Apollo hospital &DrSohiniVerma –Rs 1 crore.

It may be noted that In Motor vehicle accident cases, the compensation is calculated by the Multiplier formula. The formula is somewhat like this: 70 minus age of patient at the time of death X annual income + 30 % inflation minus 1/3rd as personal expenses. In medical negligence cases , the courts have not restricted to this formula and have added other dimensions in calculating the compensation.

The basic concept of awarding compensation lies in the principle of restitution in integrumunder which a person who suffered some damage due to a wrong committed to him ought to be restored to the position in which he/she would have been had the wrong not been committed. In the medical setting it would imply that the victim of medical negligence would need to be compensated for the incurred medical expenses, future medical expenses, compensation for mental agony and physical pain , loss of consortium and even cost of litigation .

The Supreme Court judgment in Harjot Singh Ahluwalia Vs Spring Meadows Hospital , laid down another principle that can determine compensation. It answered the following questions:

1. In the case of a minor child being admitted into the hospital for treatment , can the parents of the child be held to be consumers so as to claim compensation under the provisions of the Consumer Protection Act?

2. Is the commission under the Act entitled to award compensation to the parents for mental agony in view of the powers of the commission under Section 14 of the Act?

3. Even if the child as well as the parents of the child would come under definition of the 'consumer' under Section 2(1) (d) of the Act whether compensation can be awarded in favor of both the consumers or compensation can be awarded only to the beneficiary of the services rendered, who in the present case would be child who was admitted into the hospital?

All the questions were answered in the affirmative and compensation was awarded in favor of the parents in addition to the compensation in favor of the minor child .
In all fairness , it should also be noted that Courts have occasionally come down heavily against plaintiffs making exaggerated claims of compensation and have asked them to revise their claims to reasonable figures or risk their case being dismissed .

Nazia Sultana vs Dr. Gulshant Panesar

Complaint: The patient visited the clinic, where Laser hair removal was done by the assistant of the doctor, who was not a doctor by himself. It resulted in burns and hyperpigmentation. Following this 50% glycolic acid + Mesoglow was recommended, but it further caused burn at the chin. The whole procedure cost Rs 10000 . The patient demanded a compensation of 50 lacs

Verdict: Court dismissed the plea as the compensation asked for was very high, giving an option to file a new case again with request for lower compensation.

Thus compensation in medical negligence cases go beyond the multiplier formula and the Supreme Court has decreed that this is fair and just.

If a 35 year old patient who had a monthly income of Rs 2 lakhswere to have died due to medicalnegligence, the amount payable as compensation would be calculated thus:

70 – 35 = 35 X 24 lakhs = 8.5 crores. Add 30 % (inflation) = 10.92 cr Minus 1/3rd for expenses if he was alive = 7.28 cr. Add to this mental anguish to the family and litigation costs. Total will amount to Rs 8 to 9 crores. In the same case, if the income had been Rs 5 lakhs per month, the compensation amount will be over Rs 20 crores.

These judgments have petrified most doctors and hospital administrators (at least those who read newspapers!) though there are many who are blissfully ignorant of these developments.

Unfortunately , currently , the problem with compensation awards against doctors and hospitals is that there is inconsistency , arbitrariness and unpredictability in the awards by the various courts.The quantum is entirely dependent on the discretion of the court.

This is especially evident in non-fatal cases where compensation has been demanded not for death of the patient but for complications following treatment wherein permanent damage or disability may have resulted. For instance post-operative infection, disfigurement, under or over-correction, scarring, asymmetry and so on .

Occurrence of serious adverse drug reactions such as Steven Johnson syndrome is another important cause for demanding compensation. The quantum of compensation demanded could vary in various situations based on individual circumstances. Thus a scarring or disfigurement in a person aspiring to be a model or actor could evoke greater sympathy from the courts and be considered meritorious of a higher compensation. As said earlier , it depends entirely on the discretion of the judge and there is no laid down formula for this.

The Supreme Court has in fact noted the following :

"The lack of uniformity and consistency in awarding compensation has been a matter of grave concern. If different tribunals calculate compensation differently on the same facts, the claimant, the litigant and the common man will be confused, perplexed and bewildered. If there is significant divergence among tribunals in determining the quantum of compensation in similar facts, it will lead to dissatisfaction and distrust in the system"

In the USA , when multi-million dollar compensation pay outs started crippling their healthcare system , a need was felt for 'capping' or limiting the astronomical damages that were being awarded. This restriction was sought to be applied particularly to the non-economic damages (i.e. for pain ,suffering and mental anguish as well as what is called loss of consortium} These are difficult to calculate and there is no formula for it. These were being awarded arbitrarily and were huge and hence the demand for 'capping'. Some states in USA like California, passed laws capping the compensation to even as low as 2, 50, 00 dollars. As a result , the Annual Malpractice Insurance premium in Los Angeles (California) for an Ob/Gyn specialist is 50,000 dollars .Compared to this the premium for the same specialty is 1,40, 000 dollars in Chicago (Illinois) and 1,75,00 dollars in Long Island (New York) because these 2 states do not have Capping of compensation.

A similar thought process has started in India following large compensations awarded by courts, as illustrated above.

What is the justification for huge compensation payouts?

The proponents of large payouts advance the following justification:

Large compensation payouts send out a strong message to negligent or unscrupulous doctors and hospitals and act as an effective deterrent. No other redressal mechanism available to patients does this. A patient activist says: "Large payouts are the only way of improving healthcare in India.Medical Councils have failed to regulate the conduct of doctors"

I will analyze this justification a little later.

Will large compensation awards achieve the stated objective and what will be the fall-out that can be expected?

The Americans are still reeling under the effects of astronomical awards being handed

out by the courts. The fall-out is quite apparent and if one were to study it, one would get a pretty good idea of the shape of things to come in our country as well if this trend continues.

It will not be surprising if this triggers off and replicates the worst aspects of American health care in India. This will be disastrous as (a) governmental healthcare spending is miniscule and the majority of citizens depend heavily on private doctors and hospitals (b) medical insurance penetration in the population is meager (c) the judicial system which is already hopelessly clogged ,inefficient and tortuous will be in danger of being choked further.

Will practicing defensive Medicine become inevitable for Indian doctors ?

Defensive medicine means doctors ordering tests and procedures, making multi-specialty references and taking other measures not because the patient need these but in order to protect themselves from any potential malpractice liability.

In the USA 82 % of physicians order more tests than are necessary, 650 million dollars are lost by American healthcare system because of unnecessary tests and procedures in the process of defensive medicine.

In India, after medical services coming under the purview of the Consumerlaws, defensive medicine got legitimacy in view of 'consumerization' of the patient. The recent massive compensation awards could only provide a boost for such defensive practice.

- The need for enhanced Professional liability insurance cover has already become evident and AMC is presently advising its members to indemnify themselves for at least Rs 1 crore and much more if they practice high-risk specialties.With more number of claims and higher quantum of compensations awarded, the cost of this insurance (which of course will be passed onto the patient / consumer) can only rise.
- High compensations can only further enhance the risky and hazardous nature of pursuing a medical career, as if , fear of physical assaults by patients and relatives was not enough to dis-incentivize the bright young students from opting for Medicine as a profession. This is already evident in coffee table conversations in drawing rooms across the country like in "Your daughter wants to take up Medicine? Is she mad?"
- It is well-known that doctors in the USA are now retiring very early. I am personally aware of my several friends and relatives in US who have opted out of the medical profession at a young age, undoubtedly because of the risk perception of continuing to practice. This is likely to replicate in India and one can well imagine the situation it will create in a country where the doctor-patient ratio is already hopelessly skewed. The country will lose out on the expertise and experience of thousands of doctors who may even be at the peak of their careers. Almost on a regular basis , I have been receiving enquiries from colleagues , the medico-legal implications of leasing out their Nursing home premises to other

- agencies—whether medical or non-medical and the common thought process is : It is now getting increasingly hazardous to continue practice---physically, mentally and financially. The hostility of patients is now quite apparent and perceptible and it is difficult to give your best if you are constrained to look upon every patient as a potential plaintiff!
- Compensation or damages awarded to a patient or relatives should not become a bonanza, largesse or source of profit. But this is what huge compensations may end up becoming and may be looked forward to as a lottery or jackpot.

Should medical accidents be compared with road trafficaccidents?

Injuries arising out of medical accidents are being equated to injuries arising out of road traffic accidents Is it fair to do so? What are the differences?

- If everyone –motorists, pedestrians and traffic regulators ---were to be careful on the roads, there should be no accidents at all.
- Victims of road accidents are healthy individuals (or were so until the accident took place)
- In the medical setting, sick and diseased individuals with pre-existing medical risk factors are undergoing attempts to cure them of their infirmities and all actions are being done in good faith for the benefit of the persons presenting themselves. Some are suffering from incurable, even terminal conditions. Many of them may have unsuccessful outcomes of treatment. And even if everyone concerned were to be diligent, accidents, mishaps and complications, unlike in road accidents, will occur. Comparison with road accidents is positively untenable and it would be a travesty of justice to do so.
- One of the objectives of Compensating road accident victims, as is sought to be applied to medical accident cases, is deterrence of carelessness of drivers of vehicles. However, in medical cases , it is important to remember that though compensations will deter carelessness by doctors , it will also deter the desirable risk-taking involved in crucial medical decisions which may optimize chances of recovery of the patient --- especially in life-and-death situations. Fear of being foisted with liability will take away what may be the only chance of recovery of the patient in a given situation.

If at all, the concept of no-fault compensation, like that existing for road traffic accidents, ought to be looked into. In other words, for a medical accident victim, it should not be necessary for the claimant to prove that someone was negligent and he/she should be compensated irrespective of that fact. An exclusive Fund or Corpus should be created and a methodology for the same should be devised. Such a system exists in New Zealand, where the compensationfor permanent injury arisingout Medical treatment is paid by a corpus/fund created by the Government. However, for the Government to Fund Healthcare Injury (error OR accident), it needs to initially fund the service (Healthcare) itself! Compared with a medical malpractice system, the New Zealand system offers more-timely

compensation to a greater number of injured patients and more-effective processes for complaint resolution and provider accountability.

Should not courts factor in the woeful lack of healthcare infrastructure in our country while upholding charges of negligence against a doctor? Government spending on healthcare infrastructure is a miserable 1 % of the GDP, lesser than many underdeveloped African countries. Should we implement a first world regulatory structure (large compensations) in a country with pathetic infrastructure (poor blood banking system, shocking lack of qualifiednurses and paramedical personnel , non-existing emergency response systems and primitive ambulances and so on) which leaves doctors hamstrung in exercising their professional skills .Should not Government be penalized for it and made to compensate for being negligent rather than the doctor who is working under difficult conditions not of his making ?

It is estimated that there is a shortage in this country of 1 million doctors, 2 million nurses and 3 million hospital beds.

Another moot point that calls for a debate is the fact that since quantum of compensations is being linked to the earning capacity of the patient, should it not be considered reasonable if a differential system of charging professional fees by doctors based on the earning capacity of the patient is put in place.

The advisory that is now making therounds amongst doctors is that whilst taking the medical history of the patient; do not omit to record the income of the patient as it will help you to determine whether or not YOU can afford the patient in the event of a malpractice claim against you!!

I believe efforts are being made to get the Central Govt to intervene in the form of an inter-ministerial committee to introduce maximum limits in compensation payouts to s materializes some sanity will return to the system which is otherwise likely to spin out of control with fatal consequences for the health care delivery system. In any case, the fact of the matter is that we are poised at the brink of what the Americans have gone through and call the Malpractice crisis situation!

2 : Amniotic Fluid Embolism Medico-Legal Sequelae and How Obstetricians Can Defend Themselves

Amniotic fluid embolism (AFE) is one of the most dreaded and catastrophic complications of pregnancy in which amniotic fluid, fetal cells, hair, or other debris enter into the maternal pulmonary circulation, causing cardiovascular collapse. Amniotic fluid embolism is a clinical syndrome of hypoxia, hypotension, and coagulopathy that results from entry of foetal antigens into the maternal circulation.

SALIENT FEATURES OF AFE

- It is a very rare condition.
- It may hit suddenly like a bolt of lightning.
- It is also called Anaphylactoid syndrome of pregnancy and is often referred to by the acronym AFE.
- The etiology is largely unknown.
- It occurs in healthy women during labour, during caesariansection, after abnormal vaginal delivery or during second trimester of pregnancy .It may also occur up to 48 hours post-delivery, after abdominal trauma and during amnio-transfusion. It can also occur during abortion.
- It is very difficult to diagnose Amniotic Fluid Embolism because the clinical picture can be very similar to other complications like eclampsia, septic shock, placental abruption and uterine rupture.
- On account of the fact that it is difficult to diagnose, it is noteasy to determine the exact incidence.
- Most survivors have neurologic deficits.

- **SOME AVAILABLE STATISTICS**
- There is a dearth of Indian statistics perhaps on account of poor reporting.
- Amniotic fluid embolism (AFE) has been identified by the UK Confidential Enquiry into Maternal Deaths as a leading cause of maternal mortality with some evidence that fatality is decreasing in the UK. Estimates of incidence vary between 1 in 8000 and 1 in 80,000 pregnancies.
- However, one study gives the figure of 1 per 20,000 birthsthough a study from North America cited the figure as 1 in 40,000 deliveries. Another estimate is 2 to 6 in 1, 00,000 pregnancies.It is evident thataccurate figures are hard to come by.
- The mortality rate of AFE is high. It accounts for 10 % of all maternal deaths. Mortality estimates vary widely (from about 20 to 90%), the syndrome clearly poses a significant risk. Amniotic fluid embolism is one of the most likely causes in women who die suddenly during labor,.
- Maternal mortality approaches 80%. However, it was 61% in the US national registry, which listed 46 cases.
- Amniotic fluid embolism (AFE) is the cause of 5-10% of maternal mortality in the United States.
- Of patients with AFE, 50% die within the first hour of onset of symptoms. Of survivors of the initial cardio respiratory phase, 50% develop a coagulopathy.
- A population-based study using the California Office of Statewide Planning and Development database reviewed 1,094,248 deliveries over a 2-year period. Of 53 cases of AFE, 14 patients (26.4%) died and 35 patients (66%) developed DIC.

- Maternal survival is uncommon, although the prognosis is improved with early recognition and prompt resuscitation. The United Kingdom AFE registry reported a mortality of 37%; of the women who survived AFE, 7% were neurologically impaired.
- Neonatal survival has been reported to be 79% in the US registry and 78% in the UK registry. The intact infant survival rate is 70%. Neurologic status of the infant is directly related to the time elapsed between maternal arrest and delivery.

CAN AFE BE PREVENTED?

The answer: There is no way to prevent AFE since its pathophysiology is unclear. It is unpredictable as no risk factors have been identified

MEDICO-LEGAL SEQUELAE TO AFE

Following the devastating event of a mortality or morbidity from AFE the possibility of allegations of negligence on the Obstetrician,Anesthetist and other members of the treating team are quite high. A complaint under the criminal law, a civil case for demanding monetary compensation and a complaint to the Medical Council for disciplinary action are the usual avenues for grievance redressal.

This is harsh on the Obstetrician and her or his team because they are indeed the second victim(s).

However, several cases of AFE have landed in various courts and Forums in India including State and National Consumer Forums, Criminal complaints and complaints before various State Medical Councils. I did a cursory survey and could identify at least 11 cases (under CPA) in which final judgments were delivered in cases of AFE. If I were to deep dive, I may be able to unearth many more including Medical Council and criminal litigation.

In the course of my analysis , the allegations of the complainants, the defenses offered by the Obstetricians and the observations of the judges were very educative and revealed a road map into the labyrinthine legal system which could help in defending the doctor, though with a number of caveats.

In this blog I am presenting only one judgment, one which should bring relief and reassurance to practicing Obstetricians. This was delivered on 18th June, 2020 by the National Consumer Disputes Redressal Commission. Most of the other judgments were case specific, as all judgments are, but I will share the trend as I proceed.

BRIEF FACTS OF THE CASE:

On 4th November, 2012, Dr Manisha Agarwal, an Ob/Gyn consultant in Ghaziabad district, U.P, admitted a patient in her Nursing home with labour pains. In spite of good labour pains there was no progress of labour and in view of foetal distress, the patient and relatives were informed the need for LSCS.

However, they were reluctant to give consent for the same. It is only when they were told to either give consent or take the patient to another hospital did, they relent and give their informed consent and the operation was commenced under SA administered by Dr Neelam.

A healthy female baby was delivered but soon after the patient suddenly developed cardio-respiratory arrest. CPR was initiated, patient was intubated and positive pressure respiration started. Amniotic Fluid Embolism was suspected. The patient responded to the resuscitative measures and the operation was speedily completed. The relatives were informed of this sudden unfortunate development and the need to transfer the patient to a tertiary care hospital. Accordingly, the patient was shifted to the nearby Yashoda hospital in an ambulance accompanied by Dr Manisha. The patient was put on ventilator support.

Subsequently, the patient did not recover from the cerebral hypoxia and continued to be comatose. Thereafter, the relatives filed a complaint before the UP-State Consumer Forum alleging negligence and deficiency in service (including incompetence and lack of facilities in the Nursing home) and seeking a compensation of Rs 99 lakhs.The complainant also filed a complaint before the UP State Medical Council for disciplinary action.

On 16th May 2018, the State Commission, Lucknow held the doctor and Nursing home liable for negligence and awarded compensation. Soon after Dr Manisha appealed against this judgment before the National Consumer Disputes Redressal Commission in Delhi. The case lasted about 2 years and the National Commission passed its Order as recently as 18th June 2020.The Order of the State Commission was set aside and the complaint was dismissed thus giving relief to Dr Manisha.

A few important excerpts from the judgment:

"In the instant case the OP 1 is qualified as an Obstetrician and experienced one. LSCS was performed as per standard procedure, but unfortunately the patient suffered cardiac arrest due to unpredictable Amniotic Fluid Embolism (AFE). Though immediately resuscitative steps were performed by the doctors in OT, the patient suffered cerebral hypoxia, it was not due to negligence or deficiency while conducting the LSCS or management of AFE.

The State Commission has erred in law to hold it as medical negligence" "We have gone through the literature on Amniotic Fluid Embolism from the various published Articles andthe medical text from William's Obstetrics (23rd Ed). It is stated therein that Amniotic fluid Embolism is a rare but often fatal complication of pregnancy and its onset can neither be predicted nor prevented.

AFE is an infrequent, unpredictable, and the catastrophic complication of pregnancy in which amniotic fluid, fetal cells, hair, or other debris enters into the maternal pulmonary circulation, causing cardiovascular collapse. AFE is a syndrome typically occurs during labour, soon after vaginal or caesarean delivery, or during second-trimester dilation and evacuation procedures. It is virtually impossible to predict which patients are at risk for AFE.

Diagnosis must be based on a spectrum of clinical signs and symptoms and by exclusion of other causes. Most cases of AFE are associated with dismal maternal and fetal outcomes, regardless of the quality of care rendered. Early recognition of AFE with prompt intervention is paramount to a successful outcome. Management is resuscitative, geared toward maintaining vital signs and treating hemodynamic and coagulopathy derangements as they occur.

A team approach among obstetrician, anaesthesiologist and intensivist is necessary for a successful outcome. Despite early intervention, maternal and foetal mortality remain high. Thus, owing to its uncertain etiology, varying symptoms, rapid onset, and high fatality rate the AFE is one of the most challenging obstetric emergencies leading to cardiac arrest."

The following wise words appear at the top of the judgment:

The blame of tragic misfortune for unexpected, unavoidable, unpredictable, unpreventable Amniotic Fluid Embolism (AFE), most of the times the obstetrician is a scapegoat. Unfortunately, in some cases, despite the doctor's best intentions, patients suffer injury or die, and the clinicians involved often become the secondary victims.

Comment: This judgment puts allegations of medical negligence in a case of Amniotic Fluid Embolism in the correct medical and legal perspective Thank God! It will form a good precedent to be appropriately quoted in a similar case in future.

(Dr. Manisha Agrawal & Anr. vs. Kapil Bajaj & Anr. on 18 June, 2020)

DEFENDING MALPRACTICE ALLEGATIONS IN AFE LITIGATION

As can be seen from the above judgment, courts are recognising the inevitability of certain medical complications and taking into consideration medical literature before fastening liability to the doctors.

However, it must be remembered that not all cases end up in favourable judgments as in the illustrative case above.

Following key points should be noted:

- Mere occurrence of AFE with consequent mortality or morbidity can be easily defended on the basis of ample world-wide medical literature available on the subject.

- However, it is vital to give evidence to the court that post the event, early recognition and prompt intervention happened. Duly documented clinical measures which were taken ought to be produced.

- Since AFE is otherwise defensible, advocates of plaintiffs raise other issues to establish their claim. Some of these are:

a) Related to informed consent

b) Wasting crucial time due to delayed transfer.

c) Creating doubts in thediagnosis, typically, by listing the differential diagnosis of sudden cardiovascular collapse during delivery viz

- Total spinal anaesthesia
- Drug anaphylaxis
- Air embolism
- Venous embolism
- Septic shock
- Nursing home/hospital not well-equipped.

CAUTION:

NEVER GIVE DEATH CERTIFICATE IN A CASE OF AFE. POST MORTEM SHOULD BE ORDERED.

Only PM can confirm AFE. Despite voluntarily declining PM, relatives often make the specific allegation that PM was not done to conceal the real cause of death of the patient.

MESSAGE OF HOPE FOR OBSTETRICIANS

Out of 11 judgments pertaining to cases of AFE 7 of them exonerated the defendant doctors and the complaints were dismissed. Hence over 70 per cent of litigation ended in favour of the doctors in the Indian courts!

3 : Medical ethics And Law : Complementary Or Conflicting?

Since the evolution of mankind, efforts have been made to regulate the behavior of individuals and groups of individuals in society by voluntarily enunciating a code of ethics for their respective members. Ethics has been defined as a science of moral principles. In fact, ethics is something that has to do with your conscience. It is a code of conduct, a way of behavior, almost a way of life. For all practical purposes, the words "ethical" and "moral" areinterchangeable. At one time, it was like advice from a father to a son. There are some who believe that ethics cannot be taught, it can only be inculcated, especially by example. The oldest code of ethics for medical practitioners was the Hippocrates oath which formed the basis for a self-inflicted code of conduct.

We have to understand the relationship between Medical Ethics and Law before we try to answer the question – Are the two complementary or conflicting? The link between Ethics and Law has been very neatly summed up thus- “Law cannot reach where enforcement cannot follow. Hence, ethics begins where the law ends or cannot reach.”

The fact of the matter is that Ethics cannot be considered in isolation of Law or vice versa. Ethics and Law are cognate i.e. "related to or descended from a common ancestor." Hence, there is considerable overlap between Ethics and Law. They cannot be taught separately, and undoubtedly, they are complementary.

Historically, as we said earlier, the code of conduct was self-inflicted. However, with the passage of time, evolution of society, with the tremendous scientific progress and rapid industrialization there was a sea change in the social and cultural behavior of the people. The number of physicians increased greatly and the relations between physicians were wedged by several interacting forces –politics, government, law, media, etc. It became necessary to frame statutory measures enforcing the principles laid down in the code of ethics and that is how Medical Councils were born.

The mind-boggling advances in Medicine and Technology keep aggravating the dilemmas of doctors and society and the margins between Ethics and Law become more and more hazy and the common lineage between the both becomes more evident. How does one determine where Law ends and Ethics begins It is true that Law is lagging hopelessly behind, the advances in Medicine-not having kept pace with progress in Medicine.

Genetics, Prenatal testing, organ donation, stem cellapplications, abortions, end of life issues, surrogacy are all areas which have thrown up numerous challenges which are unaddressed by law and have created painful predicaments for doctors. It must also be recognized that though Medical Ethics and Law can be considered complementary, there are areas of dissonance andconflict. For example, under the Code of Ethics, a medical practitioner gives a solemn declaration: "I will maintain the utmost respect for human life from the time of conception". And yet, every day doctors are terminating human life by way of abortions since they have the force of Law with them. Thus, terminating a life-in the making could be Legal, though unethical. This could of course vary from geographical region to region. The same act could be both illegal and unethical in a country like, say, Ireland but not so in India. In other words, an act could be illegal but ethical and yet on the other hand, an act could be legal yet unethical.

An example of the latter pertains to dichotomy of professional fees. There is no Law or Statute in India, not even an Income Tax law, which is violated in case of fee-splitting. However, what can be invoked is the violation of the Code of Ethics which specifically prohibits such an act. Hence, fee-splitting is not illegal but it is unethical!

There is another area of conflict, which is worthy of note. TheMedical Code of Ethics states unequivocally: "In an operation which may result in sterility, the consent of both husband and wife is needed. "This is in direct conflict of the Law which emphasizes that, for a sterilization operation, consent of the spouse is notessential! Where does this leave the poor doctor? Does he follow his Code of Ethics or should he follow the Law? And consider this from the Code: "6.6. Human Rights: The Physician shall not aid or abet torture nor shall be a party to either the infliction of mental or physical trauma or concealment of torture inflicted by some person or agency in clear violation of human rights"

Where does this leave the jail doctors and the doctors being part of a team executing a capital punishment?

It is hence amply clear that though Medical Ethics and Law are supposed to be complementary: there are areas of conflict which need to be resolved. Also, with the rapidly changing healthcare scenario in this country, the relevance and applicability of the Code of Ethics needs to be re-looked into and made modern and more in sync with the times. Undoubtedly, the principles enshrined in the code of ethics are extremely noble and the spirit of these should never become irrelevant. However we need to re-visit this Code. I am afraid, if this is not done, it might soon become anachronistic and a historical document. Apart from the unprecedented advances in Medicine, our Society itself has undergone a tremendous metamorphosis. Materialism, greed and self-centeredness is the order of the day and our sense of right and wrong is totally blurred. Exemplary, unselfish behavior is no longer looked upon as a model to be followed but on the contrary, has become a target of ridicule and derision.

Industrialization and rapid urbanization have led to the depersonalization of human relationships in all walks of life—whether between students and teachers, children and parents, employees and employers. In such a milieu is it realistic to expect the doctor-patient relationship to remain an exception and to remain insulated from the changing equations all around?

Healthcare is now a multi-billion dollar "industry" and growing by the day. Healthcare is now a marketable commodity. The mind-boggling advances in Medicine and Technology keep aggravating the dilemmas of doctors and society and the margins between Ethics and Law become more and more hazy and the common lineage between the both becomes more evident. How does one determine where Law ends and Ethics begins. It is true that Law is lagging hopelessly behind, the advances in Medicine-not having kept pace with progress in Medicine.

In such a milieu, the elaborate prescribed code of medical ethics is bound to take a back-seat. Whereas in earlier days, medical studentswere exhorted to master the art and science of Medicine, it is now inevitable that they master the art, science and commerce of Medicine!

However, it is precisely in such circum - stances that there is heightened need for auto-regulation so that Medical Ethics can truly complement the Law. But this can only happen, if the provisions in the present Code of Ethics are re-visited. We may need to delete, revise, modify, modernize, and even rationalize some of the provisions. The Medical Council Act is flawed piece of legislation and needs re-crafting. The Medical Councils need to get greater autonomy and freed from the interference of politicians. When a wealthy philanthropist in the USA made efforts to have endowed in his name a Chair of business ethics at the Harvard Business School, his offer was politely refused by the Dean of the institute on the ground that there was no such thing as ethics in business! This is precisely what happens when there is an awesome mushrooming of the various kinds of peddlers of the medical commodity resulting in unabashed and virulent marketing.

To sum up, we have a situation in which

there is blatant Commodification of healthcare, Commercialization of medical education, Consumerisation of the patient and Corporatization of hospitals -----and the picture is complete!

In such a scenario, ethics, complementary to Law or otherwise, can easily be relegated to the back burner and ethics will then truly become a matter of your conscience!

4 : Medico - Legal Implications Of Nosocomial Infections

Most of us believe that infections occurring in patients post-operatively or post-admission infections occurring in patients admitted to hospital for medical treatment, can be labeled as complications and need not be a matter of concern medico-legally. However, this is not true.

T his is a subject that has been discussed inadequately and we ought to analyze it's possible implications to obtain a proper perspective .This would perhaps; prompt us to adopt heightened preventive measures.

Nosocomial infections, also called "hospital-acquired infections", are infections acquired during hospital care which were not present or incubating at admission. Infections occurring more than 48 hours after admission are generally considered nosocomial. Definitions to identify nosocomial infections have been developed for specific sites e.g. urinary, respiratory and surgical site infections.

Let us consider an example of an easily diagnosed and dramatic category of hospital acquired infection.

An Ophthalmologist in a private nursing home posted 5 cases of cataract surgery on a particular day. Post-operatively, 3 of these cases developed infection and the patients lost their vision .The patients were all retired school teachers. A lot of media coverage followed and the Govt even appointed an expert committee which inspected the operating facilities, etc. . The findings of the committee indicated negligent practice by the surgeon leading to hospital acquired infection as a result of which the patients had lost their eyesight.

A Consumer organization helped the patients file a complaint before the Consumers Redressal Forum. Our medico-legal cell considered this case to be 'indefensible' and an out-of court settlement was negotiated and concluded.

Hospital acquired infections (HAI) are an important cause of mortality and morbidity. It is estimated that in the USA, nosocomial infections account for 2 million infections, 90000 deaths and 4.5 billion dollars in excess healthcare costs every year.

Alarmed at these figures and pressurized by the public, 15 States in the USA have through legislative action mandated public

eporting of hospital acquired infections. Many other countries have put in place legislations and protocols for dealing with

HAI which is considered to be in the domain of public health legislation.

A case in a leading Mumbai tertiary care hospital raises a number of issues, many of which, to my mind, are still unresolved. A patient was operated for vaginal hysterec tomy. Though a whole lot of pre-operative investigations had been carried out, HCV test was not done. Post-op the patient made an uneventful recovery and was discharged. Though 2 Units of blood had been reserved for her, no transfusion had been necessary. A month later, the patient developed jaundice .On subsequent investigations advised by a Physician, she tested positive for HCV. On learning of its long-term implications , the patient filed a complaint in the Consumer Forum claiming that she had acquired the infection during her hospital stay on account of the negligence of the doctors and hospital and she deserved to be compensated for the same. Irreparable and grave harm had been caused to her by this negligence resulting in an incurable disease. A sum of Rs. 25 lakhs was claimed as compensation.

The following points were raised by the complainant:

1. Patient had been thoroughly investigated pre-operatively and had been certified free of all diseases.
2. Two physicians had clearly told her that HIV C could only have been contracted during surgery or in the subsequent hospital stay.
3. She had never received any blood transfusion in the past .The only reason she contracted HCV was due to use of contaminated instruments, syringes, and etc. while in hospital.
4. All doctors, nurses, assistants and technicians ought to be periodically screened to ensure that they were free of all viruses and infections which they could transmit to the patients whom they dealt with. There is no evidence that the hospital had any such system in place.

The Surgeon contended that surgery had been uneventful and no blood transfusion had been necessary. Her surgery was done under complete aseptic precautions and disposable equipment including gloves, syringes, etc had been used. Instruments had been sterilized as per standard hospital protocol and no unsterile instrument had been used. He further stated that he was submitting his own HCV report which was negative. However, it was a fact that patient's pre-operative HCV status was not known.

The case is still pending in the Consumer Forum and the outcome is awaited. Meanwhile, we have in it enough food for thought as far as implications of hospital acquired infections are concerned.

- Firstly, most of us routinely do HBsAg, HIV and other routine tests pre-operatively. But often HCV is omitted.
- However, despite HCV being negative, what if the patient was in the window period, and tests positive subsequently? The same would apply to HIV as well.
- What about nursing staff and attending

- doctors being periodically screened for a host of infections? What about pre-employment screening? Should it be done and is it a normal practice?
- Can a nurse or doctor who tests positive for any infection be debarred from handling patients, conducting operations? A surgeon in a leading Cancer hospital who tested positive for HIV was prohibited from conducting any surgery. Aggrieved by this decision, he filed a petition in the Bombay High Court. The Court, in its order upheld the decision of the hospital and asked the hospital to assign him administrative duties .
- Can a patient demand to know the infection status of the treating doctor?
- In the event of alleged hospital acquired infection, following legal provisions could be invoked by the patient: (1) Medical negligence –claim for compensation as damages under the Law of Torts (2) complaint under criminal law under various sections of IPC e.g. causing grievous hurt, or Section 304 A in case of mortality (3) complaint to Medical Council for violating code of ethics.
- Can doctrine of res ipsa loquiter be applied in case of HAI? In one court case it was ruled that HAI cannot come under this doctrine because infection could have occurred in the absence of someone's negligence.
- From hospital or doctor's perspective, what kind of documentation would be helpful to disown HAI?

These issues need to be analyzed specifically and we propose to do this in the next issue of GRASP. Meanwhile, readers are requested to respond with inputs.

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Brushes and Stethoscope: My Artistic Escape!

Dr Maya Bhalerao
Consultant Anaesthesiologist,
Pimpri Chinchwad, Pune.

"Art is unquestionably one of the purest and highest elements in human happiness"

As medical professionals, we often experience various forms of stress and seek ways to cope with it. Embracing a hobby serves as a fantastic escape from the daily challenges. When I made the decision to take up watercolour painting as a hobby, I had no idea where to begin, and the thought of hosting my own art exhibitions seemed like a distant dream.

A few years back, I acquainted myself with palettes, paints, and brushesbut it was a gradual process.The journey, even though enjoyable, didn't really yield gratifying results at the beginning. However, rather than being deterred by these setbacks, I channelled my dissatisfaction into a burning desire to create art that would be a source of pride. Unwavering perseverance in practice sessions gave me wings to explore more in the field and my skills began to blossom. Like finding an oasis in the desert, unexpected happy accidents really cheered me up.

In our busy professional schedules, there's very little time available to consistently pursue hobbies. So, early morning hours provide me perfect sanctuary for my artistic endeavours. It's akin to meditation for me. I get engrossed in the world of brush, palette and colours making them my trusted companions. I experience utmost tranquillity and stress-free zone that ignites spark of interest in my life.

I believe that "Art is not merely what you observe, but what you enable others to see."After achieving a certain stage, art transcends beyond lines, colours, shapes or tonal values and becomes the expression of humanity, heritage & emotions, having a universal language that connects people from all walks of life.

My Art took a philanthropic turn when I held a solo Exhibition at Balgandharv Kala Rang Mandir in Pune and solo exhibition of 110 paintings at well-known Nehru Centre Art Gallery at Mumbai. The entire proceedings were given to a Charitable Hospital for tribal people at Melghatin Maharashtra. This has not onlygiven me satisfaction but I've also discovered that Art has a power to bring about social change and is an extremely useful medium for cultural exchange.

I would like to share one example. Recently, at Anaesthesia Conference, my

painting of Sakura (cherry blossoms) caught the eye of a delegate from Singapore. He approached me with the intention of purchasing the painting to gift it to a friend suffering from cancer in the terminal stage. The story of his ailing friend touched my heart. The cherry blossoms were more than a visual delight; they represented hope and positive vibes. The painting made its way to Singapore, carrying with it the healing power of art. Beyond the canvas, art has a profound impact on mental well-being. It activates the reward centre in our brain, releasing 'happy hormones'that soothe the soul.

My water colour painting hobby has provided me a sense of identity and boosted my self-confidence. It has enabled me to connect with people of diverse background transcending boundaries of race religion and nationality.

Today, thejourney from 'stethoscope to brushes' has takenmy passion to the next level with successful completion of meaningful- impactful endeavours.

My contribution in various Anaesthesia Conferences has surely inspired many amateur artists to take up this hobby as a stress buster.

So, why not embark on a journey of self-discovery through art and experience the transformative power of creativity?

Paintings by Dr Maya Bhalerao

Open Letter To AMC

Dr Medha Bhave

The assassination of a top insurance company CEO in the USA has sent ripples of sadness, fear, anxiety and worry in the world of healthcare.

The noble medical profession of the last century has undergone technological transformation, delivering superior medical salvage, stunning surgical advances and cutting-edge cancer care, and it is not looking back. On the other hand, health care costs have sky-rocketed, not only due to the high cost of technology and medication but also due to corporatisation and inflation. The health care providers are the last on the rung of these payouts and are dependent upon either government or the new business model – the multi-city corporates who can afford to host everything –place, technology, compliance to complex rules and licences – that medical professional, coming from the middle class, cannot dream of, despite their hard work.

There is no doubt that health care should be patient centric. This is ingrained in the minds of every batch of medical students. The seniors whom they emulate are mostly of the same prototype. Unfortunately, Indian patients do not understand the reasons behind the rising costs. The old generation of the patients who once considered the doctors to be gods, has been disillusioned and the next generation continues to hold doctors responsible for each and every evil in the health care. This is compounded by the rise of private medical colleges. The cost of education in these institutes is not hidden from the public eye. However, facts are far from this fiction. The cost of healthcare is actually controlled by corporations, pharma and the tech industry. Medical education may not remain a step ladder to life of satisfaction, nobility and fair monetary gains.

It was important to create a system which will help people get the full benefit of modern healthcare at an affordable rate for every economic status.
The concept of insurance started as a social initiative way back in 1883 in Germany as a sickness fund started by Otto Von Bismarck for protecting the industrial workers for basic medical care. Contributions were from both employers and employees. Pre-paid service for teachers was provided in the USA through Baylor hospital's initiative.

With this humble start, the current insurance providers with their cashless facility, preferred provider network and risk assessment protocols have become a huge business with third party administrators

adding the cost as well as convenience for the insurance providers.

Healthcare is in the centre of profit-making businesses. Yet, it is expected to be a noble profession working above fiduciary benefits.

The only ray of hope for patients in the private sector, in absence of a highly efficient government health care system, is insurance. Insurance is the only way to safeguard the patient from this crushing financial burden. There is no denying that insurance itself is a profit-making business. It assesses risk and tailors' premiums in such a way that there is surplus income. Unless a certain percentage of claims is rejected, the companies cannot cover administrative expenses and provide reimbursements to deserving candidates. Here creeps in the uncomfortable part.

1. Pre-existing medical conditions are denied. The common issue faced by the doctors is requests by the patients to not mention pre-existing illnesses like diabetes and hypertension, in order to get the claim passed. “Write something else, doctor” is often faced by aesthetic surgeons–which has to be of course refused. But it is interesting to see that certain third-party aggregator–new online unregulated patient controllers—are able to get the claims passed!

2. Very high costs of premiums. –The significantly high price of the insurance influences the patients' decision to get treated or not, the choice of hospital and doctor. It is very upsetting to the patient not getting reimbursement despite having paid the premium. The doctors were not party to this deal but have to bear the consequences in many ways including delayed payments.

3. Partial rejections—The upper limit on room and nursing charge, rejection of seemingly unrequited doctor visits or disposable items are reasons for the rancour.

4. Interference in medical decision making- The latest tech is not allowed many times. For example, when a lipoma is removed with a long incision it is sanctioned, but if it is done through small incision by suction and ultrasound lipolysis, the charges are challenged even if they are commensurate with the old type of open surgery. A physician's visit for a burn patient on a ventilator in ICU is not reimbursable.

5. Preferred provider networks in a country like India where healthcare facilities were not widespread led to a lot of inconvenience to the patients. They had to travel, could not be treated by their trusted doctors, had to face uncertainty for the sake of cashless claims. Now with prolonged efforts by associations this clause is removed but implementation is still not smooth.

The aim of insurance was to benefit the patients.

1, Financial protection–Sudden catastrophe causing disruption in the family due to medical as well as financial crisis can be averted. In this respect, everyone who has opted for medical insurance and has not claimed it should be regarded as social contribution as his premium helps some

needy person to stay protected financially despite ill health

2.Access to healthcare– People are motivated to get treated as insurance is available.

3. Prevention and early detection–Most insurance companies provide health check-ups. They even promote exercise offering discounts if a person connects via a health app.

4. They are more and more inclusive now,

International scenario–

1, USA–High premiums, many out of pocket expenses, control of medical protocols by insurance companies indirectly.

2. India–Ayushman Bharat is implemented. It will have to be seen how the private insurance scenario changes. Will companies continue to take advantage of fine prints?

3. UK–NHS is buckling under patient loads, delayed appointments, resource shortage due to constraints in funding from the government,

The possible solutions can be

1. Expand the insurance umbrella making it affordable for everyone.

2. Government–private collaboration as MPJAY can be more convenient in structure. They should be reasonably priced for private health care providers to implement it enthusiastically. Current rates are not commensurate with the running expenses, cost of disposables and medication.

3. Pricing should be transparent. Government tries to impose price regulations which are not at all practical for private healthcare establishments as they have to pay for all commodities at commercial rates. The health care staff should be paid well for the kind of work they are doing to assist the medical professionals.

4. Patient friendly policies–Simple forms, avoiding fine prints, faster claim processing, allowing for the latest technology to be used are the ways to make the insurance policy attractive for the patient.

5. Insurance companies should not use PPNs, claim rejections despite well documented legitimate claims. The doctors employed for claim assessment should be well trained in understanding the latest advances leave alone the common terms. An insurance claim was rejected as a report of "HPE – histopathological examination" was submitted instead of "biopsy". It can be very frustrating for the busy doctors to deal with such situations.

Insurance is a social initiative. It seems to have many flaws in its present form. AMC and IMA should strive to work on this issue so that the humanity and dignity of both the patient and the treating doctors is respected. The health care advances would reach the patients for whom they have been designed by fellow humans.

Open Letter To AMC

Dr Sandeep Vaidya

Dear Sir/ Madam,

I am Dr. Sandeep Vaidya, a Paediatric Orthopaedic Surgeon and Co-Director of a 50-bedded hospital in Thane, Maharashtra. As you are aware, significant challenges are being faced by medium and small healthcare organisations like ours in dealing with insurance companies, concerning cashless hospitalisation services. These issues, if left unaddressed, threaten the sustainability of our organisations and, by extension, the accessibility of quality affordable healthcare for many patients.

Key Challenges

1. **Frozen Rate Lists Since Several Years**
- Insurance companies have not revised their rate lists for our hospital since 2019, despite repeated requests. I am sure most of us are in the same boat.
- While premiums for policyholders are increased annually citing medical inflation, hospitals are expected to operate on outdated rates, leading to significant financial strain.
- Package surgeries are particularly affected, as the rising cost of consumables and medicines has drastically reduced hospital revenues.

2. **Arbitrary Deductions at Final Settlement**
- Insurance companies often make unexplained deductions during the final settlement, even after approving amounts at discharge.
- These deductions are outside the scope of agreed MOUs, leading to wasted resources in repeated follow-ups.

3. **One-Sided Decisions on Surgery Billing Grades**
- Complex surgeries, such as bone tumor procedures, are often downgraded arbitrarily during settlement without consultation with competent specialists.
- This undermines the expertise and complexity involved in super-specialty surgeries.

4. **Bias Towards Large Corporate Hospitals**
- While corporate hospitals deserve better rates, the lack of proportionality and transparency in rate allocation is a significant concern.
- For example, Star Health Insurance recently proposed a revised rate list with only a 4% increase over 2019 rates, despite annual medical inflation exceeding 10%.

5. **Lack of Transparency**
- The root cause of many of these issues is the complete lack of transparency in rate-setting processes.
- There are different rate lists for different hospitals, creating opportunities for corruption and favouritism.

Proposed Solutions

1. **Transparent and Objective Rate Policies**

- Insurance companies should adopt a transparent rate-setting process.
- Hospitals can be objectively graded based on infrastructure and geographic location, and grade-wise rate lists should be published online for accountability.

2. **Unified Advocacy by AMC**

- This fight cannot be fought by individual hospitals. I urge the leaders of AMC to launch a collective movement to address these discrepancies.
- Initiate a dialogue with insurance companies to demand transparency, fairness, and periodic revisions to rate lists.
- If these discussions fail, more radical measures, such as a unified stoppage of cashless services, may need to be considered to ensure fair treatment of medium and small healthcare organisations.

Medium and small healthcare organisations are vital to the healthcare ecosystem, but the current practices of insurance companies threaten their sustainability. The lack of transparency and arbitrary practices must be addressed urgently. I sincerely hope that AMC will champion this cause and advocate for the interests of all healthcare providers.

Thank you for your leadership and commitment to protecting the medical community's interests.

Warm regards,
Dr Sandeep Vaidya

IT in Health care is a popular program of AMC

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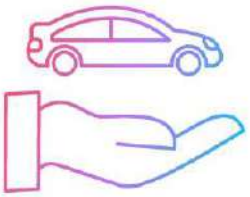

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Our Colourful Profession

Dr Manisha Ghosh

I am an anaesthesiologist and we are in mono-coloured scrubs always. For us in the medical profession, our work is worship, the hospital our temple and for us Anaesthesiologists the Operation Theatre is our sanctum sanctorum. Our day begins here and ends here, our lives revolving around this holy place, shaping our days and our future, giving us tense and happy moments, a blessing which we respect and cherish. The operation theatre is a colourful place, colour coding is a rule for ease of work and safety in the working.

This Navratri, it was a humble attempt to bring to you the "Colours of my OT" and give a little insight into our lives.

Day 1: Yellow colour

A common scene in Bollywood movies - The sinister villain, a white handkerchief soaked in some liquid pressed on the pretty face of the damsel and she faints/ becomes unconscious.

Even today, we are asked, **"who sunghani waali davai denge kyaa behoshi ke liye?"**

Well, yes, albeit in a much-refined form. Inhalational agents remain the mainstay in many Anaesthesia techniques. They put you to sleep, keep you asleep and calm, and are safe to use and recovery from these is quick. Sevoflurane is one such agent. Colour code Yellow.

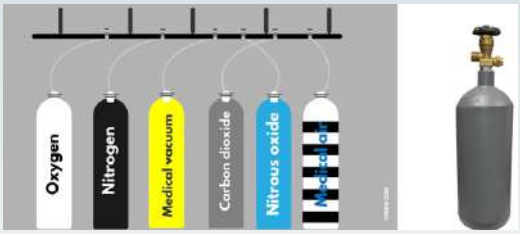
Day 2: Green Colour

When thinking about an operation, a recurring thread running through most people's minds is of a grim doctor in green scrubs, standing outside the operation theatre door; and speaking gravely to the anxious relatives. Ever wonder why green and not white?

The colour green is soothing to the eyes and minimizes the glare of the lights. It also helps to reset the surgeon's vision. Being opposite to red on the colour wheel, it provides a valuable contrast that helps surgeons distinguish between the different shades of red and pink. Hence, green scrubs and green linen.

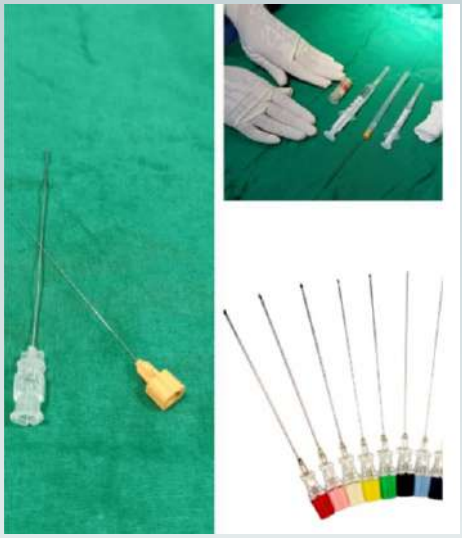
Day 3: Grey Colour

We breathe in oxygen and breathe out carbon dioxide- we have learnt this in class four. Carbon dioxide actually finds its way back in our body in a very scientific way and plays an important role in the OT. Today's fast-paced life demands early ambulation, short hospital stays, early discharge, and tiny scars. Minimally Invasive surgeries do just that. Carbon dioxide gas is pumped into the abdominal cavity, enabling surgeons to visualize the internal organs better and do what is commonly known as key hole or Band-Aid surgery. Medical gases come in colour coded cylinders, and the colour code for carbon dioxide is the colour grey.



Day 4: Orange Colour

"Oh, doctor, are you going to poke that needle in my back? Will I get backache...?" The most common anxious query from many patients. Good counselling, a few words of reassurance, proper explanation and they are ready for spinal anaesthesia. Spinal Anaesthesia is the most common form of anaesthesia for a myriad of surgeries. It remains the favourite form of anaesthesia of all anaesthesiologists. The needles, which were once upon a time stout and thick, are now refined and "almost as thin as your hair." With finer needles, appropriate anaesthetic agents, newer techniques, and an extremely skilled anaesthesiologist many surgeries from neck to toe are now performed using this method. The needles are number and colour coded. Today, I used the number 25 needle with the orange hub, the colour of the day.



Day 5: White colour

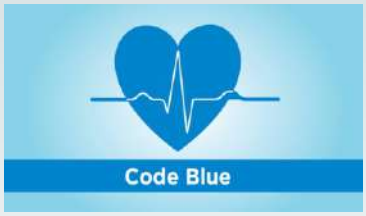
"Doctor, will I be awake? I don't want to feel anything, hear, or see anything. Please let me sleep during the surgery. " The eternal anxiety of a patient nervous about the surgery. Well, that is our job as Anaesthesiologists. To make sure that you have a pleasant pain-free experience. From no anaesthesia to binding the person down, from cocaine to alcohol, from anaesthetic gases to superior intravenous agents, anaesthesia has evolved over the years to a fine art. Today, the most commonly used and a safe agent for inducing and maintenance of anaesthesia is Propofol famously called "Milk of Amnesia"; made infamous by the tragic death of Michael Jackson. This comes with a warning:To be used by a qualified anaesthesiologist in proper settings only.

Day 6: Red Colour

Shri Netaji Subhash Chandra Bose gave the clarion call to the youth of India, " Give me blood, I will give you freedom." From the doctors, the call is," Give blood, Save a life." Red, the colour of blood, the colour of life...the most important colour in the operation theatre. A major requirement for all major surgeries, the demand far exceeds the supply. However daring be the surgeon or the Anaesthesiologist, they will not start a surgery without confirming the availability of blood and blood products. All young fit eligible persons must donate blood at least once a year and save a life. Who knows, tomorrow you or your near and dear one may need it!

Day 7: Blue Colour

Every hospital has a set of codes that hospital staff need to know for the safety and well-being of the patients. Hospital emergency codes are coded messages often announced over a public address system of a hospital to alert staff to various classes of on-site emergencies. The use of codes is intended to convey essential information quickly and with minimal misunderstanding to staff while preventing stress and panic among visitors to the hospital. Mock drills are carried out regularly to ensure coordination and smooth functioning. The most common code is that of Medical Emergency called Code Blue.



Day 8: Pink Colour

The fear of needles makes many men shiver. But these needles are not just a means for intravenous fluids and medications, they are your lifelines. Veins come in various sizes. From the very obvious ones on most adults to the really thin ones in infants, some very fragile in the old, while others hiding behind layers of tissue. Anaesthesiologists with practice over the years have mastered the technique of cannulation and there are many occasions when we are specially called to secure the difficult ones. The intravenous cannulas are again numbered and colour coded. For most adults the number 20 cannula is used, colour code is the colour of the day, pink.

Day 9: Purple/Violet Colour

One of the most commonly asked questions after surgery by anxious relatives is, "How many stitches, doctor?" Stitches or sutures, as we call them, have an interesting history. Sutures have been mentioned in detail by the Indian sage Sushruta in 500BC. The oldest known suture is in a mummy from 1100 BC. From plant materials like flax, hemp, and cotton to animal material like hair, tendons, silk, and gut, all have been used as sutures. The industrial chemical revolution in the 20th century gave us the first synthetic thread. Today, we have a variety of suture materials, specific to various tissues and organs, thicker ones for tendons to very fine ones for the eye and aesthetic surgeries. All suture materials are number and colour coded. One of the most commonly used suture materials, "Vicryl" is colour coded with today's colour of the day, purple(violet).

'Shri Gauranga Dasji, ISKON GBC & Director Govardhan Eco Village being felicited by Team AMC'

1 : Advance Medical Directives

Dr Suganthi Iyer
Director (Legal & Medical)
Hinduja Hospitals, Mumbai

Due to innovative medical technology and support systems, life is prolonged despite constant suffering.As long as there is life, people arounda sick person think that science in its progressive invention may bring about an innovative method of cure. In reality, the patient is treated like a guinea-pig or some kind of experiment for modern advanced science of managementto do unnecessary intrusion in the physical body of the person preventing his smooth exit from life.

However, it is paramount for an individual to protect his dignity as an inseparable part of the right to life. Right of self-determination is a fundamental right regarding sanctity of life and dignity of individual human being. Adult human being of conscious mind is fully entitled to refuse medical treatment or to decide not to take medical treatment and may decide to embrace death in natural way.

Advance medical directive (AMD) is a "legal document" explaining one's wishes about medical treatment if one becomes incompetent or "unable to communicate". AMD is detailed in the following Supreme Court Judgments

1. II (2018) SLT 593 – Supreme Court of India – Common Cause v/s Union of India and Ors. (WP Civil 215 OF 2005 – Decided on 9/3/2018.

2. In the Supreme Court of India – M.A. 1699 of 2019 (WP 215 of 2005 – decided on 24/01/2023)

Purpose and object

AMDis an individual's advance exercise of his autonomy on subject of extent of medical intervention that he wishes to allow upon his own body at a future date, when he may not be in a position to specify his wishes. Purpose and object of AMDis to express choice of a person regarding medical treatment in an event when he loses capacity to take a decision. Right to execute an advance medical directive is a step towards protection of aforesaid right by an individual. Such rights can be exercised by an individual in recognition and in affirmation of his right of bodily integrity and self-determination. Adult human being having mental capacity to take an informed decision has right to refuse medical treatment including withdrawal from life-saving device.

Every human being of adult years and sound mind has a right to determine what

shall be done with his own body and a medical practitioner who performs the procedure without his patient's consent commits an assault for which he is liable in damages.

AMD saves a helpless person from uncalled for and unnecessary treatment when he is considered as merely a creature whose breath is felt or measured because of advance medical technology. His "being" exclusively rests on the mercy of the technology which can prolong the condition for some period. The said prolongation is definitely not in his interest and can tantamount to destruction of his dignity which is the core value of life.

In order to overcome the difficulty faced in case of patients who are unable to express their wishes at the time of taking the decision, the concept of AMD emerged. The proponents of AMD contend that the concept of patient autonomy for incompetent patients can be given effect to by giving room to new methods by which incompetent patients can be beforehand communicate their choices which are made while they are competent. Further, failure to recognize AMD would amount to non-facilitation of the right to have a smoothened dying process. That apart, it accepts the position that a competent person can express her/his choice to refuse treatment at the time when the decision is required to be made.

An advance medical directive is "a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate".

AMD permits an individual to appoint a trusted person(power of attorney) to take health care decisions when he is unable to take such decisions.

AMD would serve as a fruitful means to facilitate the fructification of the sacrosanct right to life with dignity. It would dispel many doubts during the course of treatment of the patient. It will strengthen the mind of the treating doctor as they will be in a position to ensure that they are acting in a lawful manner. However, AMD cannot operate in abstraction but is done with safeguards as listed below:

1. **Who can execute:**

- AMD can be executed only by an adult of sound mindwho should be in a position to communicate or relate and comprehend the purpose and consequence of executing the document.
- It must be voluntarily executed without coercion or inducement
- It should have all characteristic of an informed consent
- It should be in writing clearly stating as to when medical treatment may be withdrawn or no specific medical treatment shall be given which will only have the effect of delaying the process of death causing pain, anguish and suffering to the patient and put him in a state of indignity.

2. **What it should contain:**

- AMD should clearly indicate the circumstances in which withholding or withdrawal of medical treatment can be resorted to

- It should be inspecific term with instructions absolutely clear and unambiguous.
- It should mention that the executor may revoke the instructions at any time.
- It should also disclose that the executor has understood the consequences of executing such a document.
- It should also specify the name of close relative or guardian, who, in the event of executor becoming incapable of taking decisions will be authorised to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance medical directive.
- If there is more than one valid Advance medical directive, none of which have been revoked, the most recently signed. Advance medical directive will be considered as the last expression of the patient's wishes and will be given effect to do.

3. AMD Records and preservation

- It should be signed by the executor and 2 witnesses. The document has to be countersigned by first class judicial magistrate(JFMC).
- The witness and the JFMC should record that the document has been executed voluntarily and with full understanding
- Copies of the document should be preserved in the office of the magistrate, District Court, Municipal Corporation or local government.
- JFMC has to keep immediate family aware about the AMD
- JFMC may hand over a copy of the AMD to the family physician, if any.

- **4. How AMD effected:**
- In the event the executor becomes ill with no hope of recovery, the treating Physician is made aware of the AMD who will ascertain the genuineness and authenticity of the AMD from JFMC
- Due effect to the AMD is given after ascertaining that the illness of the executor who is on life-support is incurable. The guardian is informed about the same
- The hospital where the executor is admitted should constitute a Hospital Medical Board who will form a preliminary opinion whether to certify or not to certify carrying out instructions of withdrawal or refusal of further medical treatment.
- The Medical Board constituted by the government shall take a decision to withdraw the medical treatment after communication with the executor/ guardian.
- If permission is refused by the Medical Boards, High Court shall hear the application(writ petition) and render its decision at the earliest keeping in mind “best interests of the patient”
- Procedure in Greater Mumbai
- MCGM would be the designated custodian of AMD in Greater Mumbai.
- MCGM would be responsible for secured storage and ensure to maintain integrity of the documents.
- MCGM would provide acknowledgment receipt to the Applicant upon submission.
- MCGM would upload the AMDin their portal.
- Each AMD will receive a unique reservation number which will be the

accessible to authorised medical personnel involved in secondary and tertiary care.

Advance Medical Directive is also known as Living Will.

Take Home Message:

- AMD is a valid legal document expressing one's wishes about medical treatment when one become unable to communicate
- MCGM is the custodian in Greater Mumbai
- Admitting physician needs to be updated about the AMD of his patient to give effect to the AMD
- Upholding of right to live with dignity as a part of right to life.

2 : Pacemaker Implant Cardiologist Liability

Pacemaker falls under the category of implants under Drug and Cosmetics Act. Pacemakers are inserted by Cardiologists when indicated. However, care, caution and diligence need to be exercised during insertion of pacemaker as illustrated in the case below:

III (2024) CPJ 468 (NC) -Paras Hospital V/s Rishi Kumar Jain and Ors.

Complaint:-

Mrs. Jain was admitted to Paras Hospital for chest congestion, severe cough, difficulty in breathing, uneasiness and swelling in both legs. She was diagnosed with acute left ventricular failure, dilated cardiomyopathy, coronary artery disease, LV Dysfunction with an ejection fraction of 20% and respiratory tract infection. As per the incomplete treatment and re-admitted afterfew days. Coronary angiography was performed. andwhile awaiting MRI for neurological issues, she suffered a cardiac arrest and was revived and placed on the ventilator. She continued to suffer serve cardiologist, a ventricular pacemaker implantation was advised. Detail explanation was given to the patient including relatives and consent obtained for the same and CRT – D device was implanted despite the patient's poor condition and infection. The patient's heart function and her condition worsened and Mrs. Jain expired after few days. As per the Complainant, the procedure was done by the doctors with ulterior motive. As per the complainant, the pacemaker caused the death due to negligence. The complainant added that the pacemaker implant was contaminated and beyond the expiry date, thus causing further deterioration of the health of the patient resulting in her death.

Defence:-

As per the doctors, the patient was suffering from severe left ventricular dysfunction with repeated hospitalisation for congestive heart failure and pedal edema and was on therapy for the same. The doctors were qualified and skilled professionals. Patient had lung infection and was also on

anti-tuberculous treatment with broad spectrum antibiotics and supportive care. The CRT – D implant was well within the validity period. There was indication for insertion of pacemaker implant as per clinical condition.Detail explanation was given to the patient including relatives and consent obtained for the same prior to insertion of CRT – D implant

Held:-

No expert opinion that the doctors were in any way negligent was submitted, thus ruling out medical negligence on behalf of the doctor. It is undisputed that the patient was brought in frail condition with multiple medical complications. All diagnostics were conducted on her and appropriate treatment was administered. Placing the ventricular pacemaker CRT – D implant was a planned action after due consultation of medical specialist. Necessary explanation to the patient and consent obtained prior to insertion of CRT – D implant. However, as per the Bench, it was noted that the said device was not shown to the complainant prior to insertion of the implant.

- When things go wrong somebody has to be found to answer for it as this is a human factor. However, a professional deserves a total protection and in this case there has been no medical negligence regarding the management and procedure.
- A medical practitioner cannot be held liable just because things go wrong or if he chooses one reasonable course of treatment in preference to another. As long as the doctor acts in a manner which is acceptable to the medical professional and court finds he has attended the patien twith due skill, care and diligence and if the patient still does not survive or suffers permanent damage, it would be difficult to hold doctors guilty of negligence.
- Every death does not necessarily amount to medical negligence on a hypothetical assumption of lack of due medical care.
- The medical professional is often called upon to adopt a procedure which involves higher element of risk which the doctor believes as providing greater chance of success. The usual practice is to get the consent for the same.

In the current case, there is no evidence or expert opinion to challenge the decision to implant the pacemaker or the procedure adopted for implantation or that the implant was infected resulting in deterioration in condition of the patient leading to death. It is reasonable presumption that the doctor would provide the treatment in the interest of the patient. There is nothing on record to corroborate that device in question is defective or that hospital implanted an infected pacemaker.However, at the same time it is undisputed that the said device which is of high value and specifically procured for the patient ought to have been shown to the complainant before the same was unwrapped and implanted as per the procedure.It is expected that such high value critical medical implants are shown to the concerned parties before due process. Hence, the expectation of the complainant is fair and the action of the hospital is not showing the said pacemaker to the complainant constitute deficiency.

However, it cannot be said or concluded that implanting CRT- D pacemaker was with ulterior motive or it was infected before it was implanted.

Compensation was awarded.

Take Home Messages:

- Usage of implantable prosthesis and medical devices are guided by scientific criteria inclusive of guidelines and approvals or each item
- Patients and family are counselled for usage of implantable prosthesis and medical devices
- Batch number and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record, master logbook and discharge summary
- Recall of implantable prosthesis and medical devices are handled effectively
- Implantable prosthesis and medical devices need to be shown to the family before the same is unwrapped and implanted.

3 : Birth Anomaly Negligence of Radiologist

Birth anomaly has fallen down by leaps and bounds due to newer techniques of diagnosis whilst the child is in utero. Advanced techniques in diagnostics more specifically so in radiology is now a boon for prevention of birth anomaly as these are detected much earlier and decision for termination taken. However, anomaly at birth still continues to existand could be negligence on part of professional conduct of the doctor as is illustrated in the case here in under.

III (2024) CPJ 436 (NC) – Manju & Ors. Vs Mother Hospital

Complaint:

Manju had a history of abortion during the previous pregnancy. Hence during the current pregnancyshe got her examination done and also the USG in 2nd September which indicated that all parameters were normal. This USG was done when the foetus was nine weeks and five days. She was advised by the doctor for further examination and USG at periodic intervals and more so when around 18-20 weeks in order to obtain correct picture of the formation of the foetus. The Complainant repeated the ultrasound on 10th November and the report revealed no congenital abnormality. She got herself examined on 28th December and USG was done which was reported that the position of the foetus was breech and presence of adequate amniotic fluid.

The USG was taken around 26-27 weeks and report conveyed that there was no congenital abnormality and that limbs were normal. USG was repeated on 11th March around a month before the expected date of delivery and the report conveyed a clear impression that there were no gross anomalies were noted.

The Complainant therefore went ahead with the planned delivery. LSCS was performed and unfortunately the child was born with serious limb anomalies in as much as the two legs of the baby from knee downwards were not there and the right hand from the elbow downwards was also missing.

The Complainant alleged that had these anomalies being detected at an early stage she could have exercised the option of abortion but because of the negligence and carelessness and reckless casual report submitted by the doctor, the tragedy could not be averted.

As per the Complainant there would be difficulties in bring up such a child and look after the child due to lifelong disabilities and the agony suffered by the parents. A handicapped baby will have to be nursed and cared and skilled treatment to be given lifelong.

Hence, there is deficiency and Complaint was filed in the Consumer Court.

Defence:

The hospital stated that the Complainant had been advised to conduct USG at around 18-20 week of pregnancy to detect anomalies. However, this anomaly scan was not undergone by the mother when the foetus was around 18-20 weeks which is the ideal time for detection of anomaly. It was conveyedthat the amniotic fluid had reduced and was less and therefore the level of detection of any anomaly stood considerably reduced according to medical protocols. The evaluation made by the doctors was at a stage the anomalies could not have been detected with accuracy due to the breech foetal position and the lessening of the amniotic fluid. Even otherwise the accuracy rate of such detection is between 45-50% and all anomalies cannot be necessarily detected. The Complainant failed to get the investigations conducted within the time prescribed and as intimated inasmuch the USG test of anomaly scan which was to be repeated around 18-20 weeks of pregnancy was never conducted. It is submitted that having failed to get the USG test conducted around 18-20 weeks of pregnancy, there was little chance of detection of anomaly later. Thus, it was a voluntary choice of the Complainant as she failed to get the anomaly test conducted in time to enable detection of any abnormality and hence the Complainant failed to get herself treated as per medical protocol and hence there is no liability of part of the Hospital.

Held:

- It was noted that the USG reports did indicate adequate amniotic fluids and hence the conclusion drawn by the doctor was not correct.
- The USG report conducted in December indicated no abnormality in the formation of the body. The report dated 28th December categorically stated that the limbs of the foetus are normal. The anomalies did exist which stands established post-delivery. The issue is as to whether this could have been possibly detected or nor in December or thereafter in radiological examination. Medical protocol indicated the best period for detection of anomaly is around 18-20 weeks.

- As per literature submitted by the Complainant morphological examination of the limbs in the third trimester is difficult as bone ossification increases which impairs the visualization of the underlying structures and decrease in volume of amniotic fluids. Also, secondary anatomy changes due to functional disturbances (skeletal dysplasia, segmental deformation, etc.) become evident. Thus, even in cases with a normal morphological examination in the second trimester the examination of upper and lower members should be attempted in the third trimester. In the third trimester the evaluation of the foetal well-being includes the limbs and hand movements.
- The responsibility of the patient was to be careful when she was a known case of previous abortion and should have abided by the advice of the doctors with a view for timely detection of fetal anomalies. Nonetheless, the doctor and the hospita lwere persistent that the USG reports depicted that the foetus was normal and categorically mentioned in the report dated 28th December that the limbs were normal. The USG report dated 11th March also stated that the volume of amniotic fluids was adequate. The breech position of the foetus also would create obstruction in the complete visualization of the expected growth the limb. The repeat ultrasound was done when the foetus was around 26-27 weeks old.There is no explanation or evidence to demonstrate as to why no examination was undertaken between 18-20 weeks of the pregnancy.Hence, shortcoming on part of the Complainant could be factor while assessing the liability on part of the Doctor and Hospital.
- As per expert opinion, after the expiry of 20 weeks period the anomalies cannot be detected in all patients. Hence if an anomaly scan is carried our around 18-20 weeks, then the radiologist will spend more time to study the same. This indicates that the examination and assessment should have been more seriously undertaken. There was carelessness and adhoc exercise on part of the doctors and hospital which is nothing short of negligence. There wasno indication in the report of anything inconclusive or hazy or doubtful. Inaddition, the anomaly scan done on 28th December categorically mentions that the limbs were normal.
- It was evident that the lower part of limbs and the foot were totally absent as also the right arm of the child.Thus, the limbs
- were not normal and a clear deformation existed. This was the clear case of lapse on part of the doctor who tendered the report. This was not an error of judgement but lapse due to neglect. The doctor cannot take a plea of less visibility or non-visibility of the growth of the limbs because he does not say in its report dated 28 December that he is unable to visualize the growth of the limbs. He assertively reported that the limbs are normal.This would not have been possible had he not observed the growth of the limbs. The preponderance of the probability is that the plea of invisibility is incorrect looking to clear report stating normalcy of limbs. There is no indication

whatsoever in the report about any deformity or defect or otherwise of non-visibility of the said report. If the assessment had been made after the carefully looking at the images and if there were anomalies, then there was no occasion to report normalcy.This also raises the serious doubt and it is quite probable that the doctor himself either did not scan the images or left it to someone else to perform his job. This possibility cannot be ruled out adding to the unmindful approach in preparation of the reports.

- Hence there is a lapse on part of the hospital and the doctor in detection of the anomalies during scanning.

Compensation was awarded.

Take Home Messages:

1. Radiologist to possess requisite qualification and valid registration
2. Report to be issued with care, caution and diligence
3. Delegation of reporting to be done to another radiologist who is qualified, registered with equivalent skill and care.

4 : Different Lines Of Treatment Is Not Negligence Supreme Court Judgment

When a patient comes to hospital the aim is to administer effective treatment by management of underlying medical condition. Different medical professionals may administer medical care by different lines of management . As long as the line of management is an accepted current professional practise in the concerned field of medicine, the same is acceptable by courts as is seen in the following Supreme Court Judgment

II (2024) CPJ 1 (SC)----M.A.Bivji Vs Sunita & Ors.

Ms. Sunita was taken to G Hospital on 05th May with history of car accident resulting in multiple injuries including mandibular and clavicular fracture. Tracheostomy (TT) was done to assist breathing. She was later shifted to ICU of S Hospital. Ms. Sunita was put on ventilator through the TT which was later weaned off. Mandibular bracing surgery was done. Subsequently, bronchoscopy was done for evaluation of airway, larynx and trachea which showed a normal air passage. However, the TT was removed and nasotracheal intubation (NI) was performed. In addition, Ryle's tube was inserted for feeding. Liquid feeds were started which passed into her respiratory tract and got collected in her lungs leading to frank pus and severe infection ultimately causing severe septicaemia. The pus started leaking through the stitched tracheostomy wound. Due to injuries in the subglottic region, the vocal cords became paralysed.

Barium swallow was done and Ms. Sunita experienced severe breathlessness as the

the solution went into the respiratory tract. Ms. Sunita sought a discharge and went to a prominent doctor in Mumbai who treated herfor septicaemia and difficult respiration. TT was re-inserted through the previous tracheostomy wound to aid respiration. Subsequent bronchoscopy revealed two openings in Ms. Sunita's trachea at the subglottic level. A false passage was created which caused the food to pass into the trachea. As per Ms. Sunita this was due to the NI procedure leading to multiple medical complications. Tracheoplasty was performed later for correction of subglottic stenosis resulting in a shortened windpipe. TT was removed and it was realised that Ms. Sunita has lost her voice.

Ms. Sunita filed a complaint in the National Commission for alleged medical negligence resulting in permanent damage to her respiratory tract and permanent voice loss due to the NI procedure conducted at S hospital resulting in subglottic stenosis and other complications. As per the hospital, TT had to be removed due to the risk of infections and hence NI procedure was done as an alternative. As per the National Commission, negligence was proved since though the patient was breathing normally through the TT which provides longer breathing assistance, NI was performed and there was no basis to consider replacing the

TT with NI as Ms. Sunita was recovering well breathing through the TT. National Commission slapped medical negligence and compensation including damages was awarded.

The doctors and S hospital filed an appeal in the Supreme Court.

Observations made by the Supreme Court:

a. Expert medical opinion did not find any negligence with the performing of the NI procedure replacing the existing TT. The expert committee has also opined that bronchoscopy report indicated normalcy even after TT removal. The expert committee also opined that tracheal trauma and injuries including subglottic stenosis are common after severe injuries sustained in road traffic accident. If the NI procedure had been conducted in a negligent manner it would have been mentioned in the expert report. There was no such remark in the expert committee report.

b. No other subsequent hospital or any medical record where Ms. Sunita got treated made any connection between the NI procedures and the complications.

c. National Commission has not recorded any connection between the NI procedures and the complications though the Commission has slapped negligence. The National Commission has reasoned there was no justification to opt for NI procedure as the patient able to breathe through the TT.

d. The NI procedure was conducted due to failed attempts at TT decannulation. After difficulties arising after TT decannulation, resorting to NI procedure as an alternative to provide breathing assistance in not out of place.

e. Ms. Sunita has failed to produce evidence substantiating the complaint.

f. There is no evidence to establish that the NI procedure is a bad medical practice or based on unsound medical advice. Hence, no negligence has been committed in opting for the NI procedure.

g. The text book of Dr. Atul Gowande describes the situation as a classic case of human fallibility where the doctors tried to do the best for the patient as per their expertise and emerging situations. However, the desired results could not be achieved. Looking at the line of treatment in the present matter, it cannot be said with certainty that it was a case of medical negligence.

Held by Supreme Court:

- The standard to be applied for judging, where the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against an indictment of negligence.

- The Medical Professional is expected to bring a reasonable degree of skill and reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

- Negligence is only when conduct falls below that of standards of a reasonable competent practitioner in the field.

- It would not be negligence if there is scope for difference of opinion because conclusion of one doctor is different from another doctor. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill

- and competence. Merely because the doctor choses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him is acceptable to the medical profession.

Take Home Messages:

1. Line of management of clinical condition should bein accordance with what any other reasonable medical practitioner would administer in that speciality.

2. Line of management should be currently accepted professional practise

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The Missing EQ (uation) Today

Dr (Mrs) Anupama Varma
MBBS, MD (Pathology)

I am a Clinical Pathologist in private practice and I love my work- it is my passion and has never felt like work. My daughter, who is a resident in Gen Surgery, feels her life is a big hassle and hard work!!! I also teach at the government medical college and I am seeing this feeling is very common in today's students. This made me think- what should one do or what is it that defines a successful Doctor?

From the eyes of our non-medico community, Doctors are always successful and rich!!

While our Medico community has varying Reactions -
For some who are earning well feel they are successful; some feel that practice is so stressful and it is a thankless job, I don't want my kids to become a doctor!

WHAT IS SUCCESS?
Poet Ralph Waldo Emerson says-
"Success is ….
To laugh often and much;
To win the respect of intelligent people and the affection of children;
To earn the acceptance of honest critics;
To appreciate beauty & find the best in others;
To leave the world a bit better and so on....."

I too agree with Emerson that success should not be defined by wealth, fame or social status. Rather, it should mean living life to the fullest through joy, relationships, creativity and positively impacting everyone and everything around us.

- We have all undergone the same training to become a doctor- Similar Education and Training and Learned Clinical Skills - Diagnostic Abilities, Technical Skills, Patient Management
- Developed Interpersonal Skills of Communication, Empathy, Teamwork
- Ethical Practice with Integrity and compassion
- Always involved in Continuous Learning
- Have developed Resilience and Stress Management
- We are Adaptable with respect to time, technological advances and quickly assessing and responding to unexpected situations
- Also learn Networking and build Professional Relationships

All of us are trained in these are general factors, then why is there an unspoken despair among doctors?

I feel that we have never focussed on our emotional quotient (EQ), we have always

focussed only on our intelligence quotient (IQ). Those doctors with above average EQ succeed in professional as well as their personal lives.

Emotional intelligence can help one improve their interpersonal relationships, both personally and professionally.

The five components of emotional intelligence at work are self-awareness, self-regulation, motivation, empathy and social skills.

1. Self-awareness - It is the ability to identify your emotions and emotional triggers. This is a useful ability as one can use self-awareness at work to understand how one is viewed byco-workers, seniors or patients.
2. Self-regulation –is the ability to control and adjust your emotions to create a more positive effect. You might control your emotions at workplace by adjusting your feelings to keep a professional appearance in front of patients & colleagues.
3. Motivation - is the urge and desire to do something useful; these desires can promote a way of fulfilling our own inner needs and goals along with goals at workplace
4. Empathy – is the ability to identify and understand the feelings of another person, this allows you to handle workplace situations more effectively
5. Social skills–are the tools used to communicate and interact with other people. Having stronger social skills - like effective communication and respect - allows you to listen, speak and resolve conflicts more effectively, helps in career management and are essential tools for leaders.

The benefits of emotional intelligence in the workplace include being able to better understand nonverbal cues, properly adjust your behaviour, make good decisions and become a respected leader.

Finally, most of the times, career choices are like entering into a marriage.

You are eager at the prospect of marriage before getting married; and after getting married, realize that it is different and find negative points.

Here comes the role of having a good EQ- Good EQ helps us to analyse the situation better and understand that every career/marriage comes with some positives and some negatives. EQ enables person to deeply understand the fact that it's easy to continue being in it by adjusting to the situation rather than starting afresh in any field of career/marriage in view of the investment made in terms of time, money and life time of efforts.

I will summarise my feelings by saying that Doctors are among the most intelligent sections of society very high IQ, and if they hone the art of increasing and nurturing their emotional quotient/EQ, successis sure to comenaturally and effortlessly.

Success is success only when it makes you feel HAPPY and contented.

Travelogue:

Peru's Rainbow Mountain

Dr Kritika Doshi

Hello Friends!

We have heard about and few lucky people have seen a rainbow in the sky; most of us have only imagined it from pictures. How about a rainbow-coloured mountain! One that we can see and walk on!

Intriguing isn't it!

A sudden change in our travel itinerary made us change our travel plans from Miami to Peru- while searching for unique places to see, I read about the "Rainbow Mountain"- also known as Vinicunca, the Rainbow Mountain peaks at 17,060 feet above sea level and is approximately 62 miles southeast of the Peruvian city of Cusco. The locals Peruvians regard Rainbow Mountain as a holy place, and it is considered the symbol of the father and masculinity. The mountain is said to fertilize Pachamama or Mother Earth herself. Local tradition considers this mountain to be the spiritual protector of the native people.

Being trekking enthusiasts, we had to visit this place. But how come we had never heard about it before? Everybody knows Machhu Pichu is in Peru, but rainbow mountain is unknown!

We have to credit climate change with this: despite its ancient history, the mountain was hidden from sight because the area used to be covered entirely in snow. Only recently, with the effects of climate change, was the rainbow revealed; the mountain is made up of 14 different minerals, and each mineral is represented by a different colour.

Rainbow Mountain is one of several peaks that make up a now-dormant chain of volcanoes that formed when the Nazca tectonic plate fell beneath the South American plate. This volcanic activity dredged up minerals that were deep in the Earth, which were then laid and compacted into different layers of sedimentary rocks, like sandstone, halite, gravel, clay, and other minerals.

Then as these minerals were exposed to the environmental conditions around them, like snow, wind, and water, their colours changed. Each of the hues on the mountain comes from a different mineral. The red layers indicate iron oxide rust, while the orange and yellow suggest iron sulphide. The turquoise comes from chlorite, which, interacts with the yellow to form a brilliant turquoise blue.In turn, this breathtaking attraction is sometimes called Vinicunca or "Montaña de Siete Colores," which translates to "the mountain of seven colours."

This is a day trip from Cusco- with huge number of tourists. We left at 3:00am and travelled 4 hours from Cusco (11500 feet AMSL) to the base (14000 feet AMSL) where we could park our jeep. Both the high altitude and the trail's length make for a challenging trek. We had been advised to acclimatise before hitting the trail. Altitude sickness is a real challenge. Our local guide suggested andoffered us cocoa leaf infusion; insisting that chewing on coca leaves or drinking coca tea helps. We did chew on the leaves and completed the trek without any problems!The terrain leading up to the

The weather in the region too is very unpredictable. We travelled in October which was the beginning of winter- we were fortunate to have witnessed the rainbow colours despite very little sunshine and chilly winds as company. The next day, it snowed and the trekkers did not get to see the rainbow colours at all!

Unfortunately, climate change and tourism are destroying this fragile beauty. In the few short years since tourists started climbing the mountain, hikers have eroded the 2.5-mile-long trail to get there.

We were fortunate to trek and walk on a mountain formed by millions of years geological changes and hope that this natural beauty is not destroyed by over tourism.

PCC Report

Dr Reena Wani

AMC PROGRAMS 2024-2025

Nurses Training Program 26th May 2024

The Doyen Bheeshma Pitamaha of AMC Dr SN Agarwal conducted the structured Nurses training program in collaboration with other organizations including AFG, FOGSI in Riddhi Vinayak Hospital Nallasopara. This was very well attended by 450 participants and many of our members interacted with the audience.

Workshop on NHCX Integration and IRDAI Master Circular on Health Insurance

Dr. Sudhir Naik conducted this program on Sunday 23rd June at Hotel Orchid Vileparlewhich was attended by 43 participants. There was lively interaction and the information was very useful for practitioners.

AMC Doctors' Day Celebration 30th June 2024

AMC Doctors' Day Celebration was held on Sunday, 30th June 2024, at Balghandharva Rangmandir, Bandra, from 5:30 pm to 9:30 pm.

Members were given Invitation to Showcase their Talent at AMC Annual Doctors' Day Celebration by sending out messages in advance, encouraging them to take a break from routines and shine by showcasing hidden talents. Whether a singer, dancer, musician, we had a spot for our members!

This year's categories included: - *Group Dances: □Solo Dances: □Songs /Instrumental Performances. The video entries received online were evaluated by organizing team and senior experts to shortlist the best in different categories.

Ganesha Vandana by Dr Sandhya Saharan was followed by musical performance by Dr Rajiv Das on Hawaiian Electric steel guitar. Fusion group dance was performed by Dr Heena Desai and team, portraying old and new aspects of music and dance.

The inauguration program was conducted by Dr Ashok Shukla and Dr Vikrant Desai. After lamp lighting by dignitaries and organizing team, various felicitations were done. The highlight was the Sanjeevani Trust award to Dr Suhas Kate with presentation of the work done by him over the years. Special inviteesincluding EHO Dr Daksha Shah and various teams who had done Blood donation drives, achieved FEQH were also felicitated.We

AMC - BPS WEBINAR-Hidden in Plain Sight: Spotting Psychiatric Issues in Non-Psychiatric Consultations 27th December 2024:

This was a very insightful guide for practitioners who attended this webinar (56 total) organized by Presidents of AMC & BPS Dr Vivek Dwivedi, and Dr. Ruksheda Syeda. Speaker Dr Anjali Chhabria and panellists from different fields Dr Sejal Ajmera (gynecology), Dr Sama Rais (dermatology) and Dr Girish Dewnany (ortho) gave very useful tips.

AMCON-FAMCICON 19th January 2025

The highlight of the year was of course our flagship event annual conference which was held at Taj Lands End, Bandra and had 242 registrations and 2 MMC CME points. Despite many events coinciding on the same day, including the Mumbai Marathon, IMA Conference and many weddings, the program went off very well with stellar content and excellent speakers.

...continued from page no. 68

Conclusion

Digital healthcare can transform the healthcare industry by enabling efficient and cost-effective delivery of care, empowering patients to take control of their health, and improving access to healthcare services in remote areas, but it is crucial that healthcare professionals, developers, corporations, and regulators work together to create an evidence- based, affordable, accessible, and person-centric health ecosystem.


AMCON – FAMCI
2024-2025


AMCON – FAMCICON
2024-2025


2024-2025


AMCON – FAMCICON


2024-2025


Dr. Kishore Adyanthaya
President-FAMCI
Dr. Nilesh Naphade
Dr. Reena Wani

FINNOVATE
BE FINANCIALLY FIT.

Breaking down the jargons

Specialized Investment Fund - More than a Mutual Fund

ROLE OF SIFS IN INDIAN CAPITAL MARKETS

Indian investors have traditionally complained that India had too many plain vanilla products. At the entry level, there are mutual funds with low entry barriers but the products are not too customized. At higher levels, we have portfolio management services (PMS), where the portfolios are individually customized, but they come with higher fees and a higher cut-off. While the minimum investment for mutual funds is as low as ₹5,000 for an NFO or ₹500 for a SIP / Regular purchase; the entry barrier for PMS is normally around ₹50 lakhs.

Still higher on the scale are alternate investment funds (AIFs), where the entry cut-off can be as high as ₹1 crore. This puts PMS and AIFs outside the purview of most retail investors. The need of the hour was a product in between, which would go beyond plain vanilla investing, but the entry barrier would not be too high. That is where specialized investment funds (SIFs) fit in.

HOW SIFS ARE DIFFERENT FROM MUTUAL FUNDS?

Specialized Investment Funds (SIFs) offer a mid-point positioning between a plain vanilla mutual fund and a customized PMS. SIFs have a minimum investment threshold of ₹10 lakhs for an investor. However, the real difference lies in the way the portfolio of an SIF is permitted to be structured. Let us look at some key differences between an SIF and mutual funds. Firstly, SIFs permit more concentration in specific stocks or bonds. Today, in case of equity, MF schemes cannot have an exposure of more than 10% to a particular stock. This can go up to 15% in an SIF, so the challenge of overdiversification is addressed.

Secondly, in case of bonds, the maximum exposure to a single issuer is 10% for mutual funds. However, in the case of SIFs, this limit stands raised to 20%. In special cases, this limit can be further enhanced to 25% with appropriate board approvals. Thirdly, SIFs offer greater flexibility in allocation to alternate assets. In the case of mutual funds, the maximum exposure to REITs/INVITs is 10%. This limit stands enhanced to 20% in the case of SIFs. This gives more leeway to the fund manager for opportunistic allocation of funds to promising asset classes.

WHAT THE SIF NOTIFICATION IS SILENT ABOUT?

Interestingly, there are 2 areas where the SIF gazette notification is silent on. In the original draft document presented by SEBI, the regulator had suggested allowing SIFs to structure derivative strategies like spreads, straddles etc to capitalize on sharp market movements. This would have been a genuine value addition since the traditional mutual funds only permit hedging of risk with derivatives or running a cash-futures arbitrage fund. Mutual funds cannot speculate using derivatives.

The second subject pertains to inverse ETFs. This was again part of the draft document put out by SEBI. Inverse ETFs are specialised high-risk ETFs where a combination of derivatives are used to

create the equivalent of a short selling position in the market. This can be used to bet on a market downside, and also to hedge portfolio risk. Here again, the gazette notification is silent.

WHO SHOULD INVEST IN SIFS?

Obviously, SIFs are sophisticated products with a higher degree of risk. Hence it is important that mis-selling is avoided. Today, there are many mass-affluent persons willing to put up a deposit of ₹10 lakhs. However, the fitment and awareness levels of the client are critical too. If you have a low appetite for risk, then SIFs are not for you. Also, if you are uncomfortable with higher volatility and relatively higher costs, then SIFs may not be the right product for you. However, investors can start off with a basic minimum allocation to SIFs, and test waters, while ensuring that the overall allocation is still in sync with your core asset allocation.

MAJOR ADVANTAGES OF INVESTING IN SIFS

SIFs are not just a new-fangled product, but they offer a mid-point in terms of investor choice. It is positioned above mutual funds but below PMS; in terms of complexity, return potential and costs. Here are some merits of SIFs.

- SIFs address the risk of kurtosis that mutual funds are subjected to. Even when they have a strong view on a stock, MFs cannot cross the 10% threshold. The SIF offers higher flexibility in such cases and addresses kurtosis much better.

- At a time when inflation is sticky, investors need higher returns to compensate for the macro risks. With its allocation flexibility, SIFs can continue to perform well, even when the markets are not fully supportive.

- Diversification is a key advantage in SIFs. With the higher individual weightage in equity and debt, SIFs allow concentration in select assets. This helps to diversify a largely plain vanilla portfolio that mutual funds offer.

- SIFs can address the problem of liquidity. A big challenge for investors is having liquidity when markets bottom out. That never happens in MFs. By using complex SIFs, investors can ensure profits in a fall and be liquid at market bottoms.

More importantly, SIFs offer an additional choice to the discerning investors with a higher appetite for risk.

SOME RISKS INHERENT IN SIFS

Obviously, SIFs come with some key risks too. Firstly, concentration of portfolio can be a double edged sword. It can magnify returns on the upside, but also magnifies losses on the downside. The second risk in Specialized Investment Funds (SIFs) is the risk of secondary market liquidity. While equities generally tend to be liquid, the same cannot be said of other assets. Private debt paper can often be illiquid.

Also, strategies based on far-month options or futures can also be illiquid if the exit size is large. Thirdly, SIFs will charge higher fees compared to mutual funds. The total expense ratio (TER) for SIFs would be much higher than active funds too. That can really pinch in a market downturn.

To be fair, the SIF regulations are still evolving and we could see more variety and choice in the coming years. SIFs are a good step in further stratifying investors into more granular segments.

Scan to Book a Free Consultation Call

Virtual Private Networking (VPN):

A Simple Guide for Everyone

Dr Alok Modi

In today's digital world, online security and privacy have become crucial concerns for individuals and businesses alike. One of the most effective tools for achieving this is a Virtual Private Network (VPN). This article will simplify VPNs, explain how they work, and highlight their benefits in everyday life.

What is a VPN?

- **Definition:** A VPN is a technology that creates a secure, encrypted connection between your device and the internet. Think of it as a private tunnel that shields your online activities from prying eyes.
- **Purpose:** It hides your IP address and encrypts your internet traffic, making it difficult for anyone to monitor or steal your data.

A Virtual Private Network (VPN) creates a secure digital link between your computer and a remote server managed by a VPN provider. This connection forms an encrypted tunnel that safeguards your personal information, conceals your IP address, and allows you to bypass internet restrictions and firewalls. This process ensures your online activities remain private, protected, and more secure.

- **By definition, a VPN connection is:**
- **Virtual:** No physical cables are used in establishing the connection.
- **Private:** Your data and browsing activities are hidden from others.
- **Networked:** Multiple devices, including your computer and the VPN server, collaborate to maintain a continuous connection.
- Now that you understand what a VPN is and what it stands for, let's delve into the numerous benefits of using a VPN and why it might be advantageous for you.

How Does a VPN Work?

1. Connection to a Server:

- When you activate a VPN, your device connects to a server operated by the VPN provider.
- This server acts as a middleman between your device and the internet.

2. Encryption:

- All data transmitted between your device and the VPN server is encrypted. This means even if someone intercepts your data, they can't read it.

3. Changing Your Location:

- The VPN server assigns you a new IP address. This makes it appear as though you're browsing from a different location, protecting your identity.

Why Use a VPN?

For those looking to enhance their online safety, freedom, and security, the benefits of a VPN are numerous. A VPN secures its users by encrypting their data and concealing their IP

address, making their browsing history and location untraceable. This increased anonymity provides greater privacy and more freedom to access blocked or region-specific content.

1. **Enhanced Privacy**
- Prevents your Internet Service Provider (ISP) or hackers from tracking your online activities.
- Protects sensitive information like passwords, financial transactions, and personal messages.

2. **Secure Public Wi-Fi Usage**
- Public Wi-Fi in cafes, airports, or hotels is often unsecured, making it a hotspot for hackers.
- A VPN encrypts your connection, ensuring your data remains safe.

3. **Access Restricted Content**
- Some websites or streaming services restrict access based on your location.
- A VPN allows you to bypass these geo-restrictions by connecting to servers in different countries.

4. **Avoid Bandwidth Throttling**
- ISPs sometimes slow down your internet speed based on your activities (like streaming or gaming).
- A VPN masks your activity, preventing throttling.

5. **Protect Your Identity**
- Cybercriminals use your IP address to gather information about you.
- A VPN hides your IP address, protecting your identity and location.

These are the reasons to choose a VPN

1. Secure Your Data: Sensitive information like work emails, payment details, and location tags are constantly being transmitted online. This data is trackable and easily exploitable, especially on public networks, where anyone with access can potentially intercept your personal data. A VPN encrypts your data into an unreadable code, making it accessible only to those with the encryption key. It also hides your browsing activity from prying eyes.
2. Work from Home: With the rise of remote work, VPNs allow remote workers to securely access company resources from anywhere as long as they are connected to the internet. This ensures flexibility for employees and keeps company data protected and secure, even on public Wi-Fi networks.
3. Access or Stream Regional Content: Some websites and services restrict content based on geographic location, limiting access to certain media. A VPN can spoof your local server location, making it appear as if you are accessing the content from a different region or country.
4. Bypass Censorship and Surveillance: Certain regions restrict access to specific sites and services due to government censorship or surveillance. By spoofing your location, a VPN allows you to bypass these restrictions, access blocked websites, and enjoy unrestricted online freedom.

5. Prevent ISP and Third-Party Tracking: Internet service providers (ISPs) log and track your browsing history through your device's unique IP address. This information can be sold to third-party advertisers, shared with the government, or left vulnerable to security breaches. By routing your connection through a remote VPN server instead of your ISP's servers, a VPN masks your IP address, prevents ISP tracking, and keeps your personal data private.

Types of VPN connections

Today, you'll find a wide variety of VPNs for computers and mobile, both premium and free, available for professional and personal use. Here are some of the most common types:

Remote Access VPN (Client-to-Site VPN)

A remote access VPN, commonly known as a client-to-site VPN, is one of the most widely utilized VPN types for computers. It enables off-site users to connect to an organization's network or a remote server from their personal devices. This is typically done by entering authentication credentials on a login page, which then allows the connection through a web browser.

Alternatively, users can connect to the VPN via a virtual desktop client or a VPN app, which also establishes the connection to a network or server once credentials are entered. These clients offer a user-friendly interface, provide connectivity information, and allow users to switch between various VPN features.

Remote access VPNs are popular for both professional and personal use. They allow remote workers to access company files and resources from anywhere, ensuring company data remains secure even on public Wi-Fi networks. For individual users, remote access VPNs offer greater autonomy and anonymity while browsing the internet, helping them bypass content blocks, firewalls, and ISP tracking.

Site-to-Site VPN

Large organizations often require more robust and customized solutions, and site-to-site VPNs are ideal for this purpose. A site-to-site VPN is a private, internal network made up of multiple networks within an organization, connected through the public internet to each other's local area networks (LANs). This configuration allows users on separate networks within or related to the organization to share resources while maintaining restricted access to certain assets, ensuring communication remains private and secure. Due to their scale and complexity, site-to-site VPNs are best suited for enterprise-level companies with departments spread across various locations.

Types of Site-to-Site VPNs:

- **Intranet:** An intranet site-to-site VPN connects multiple sites within the same organization via LAN. This setup is beneficial when departments across different locations need to collaborate within a closed, private network, allowing them to securely and efficiently share resources.
- **Extranet:** An extranet site-to-site VPN links sites from different organizations via LAN. This is particularly useful for an organization that frequently collaborates with third-party

- suppliers, partners, or vendors. The organization can customize the level of access between each network, ensuring that only specific resources are shared while others remain private.

Mobile VPN

- While traditional VPN providers have mainly focused on desktop users, the rise of smartphones has led to a significant increase in mobile VPN usage—and for good reason. For smartphone users seeking enhanced security and protection on the move, a mobile VPN is essential.
- Mobile VPNs offer all the benefits of a traditional VPN, plus they continue to protect data even when internet connectivity is unstable or when switching between mobile data and Wi-Fi. As long as the app is running, the VPN connection stays secure, and your device remains protected. This flexibility makes mobile VPNs ideal for travelers or for those without reliable internet access. Now I am not getting into too many technicalities, But let us understand some more basics: When a connection attempt is made to the VPN provider's remote server, the server authenticates the user and creates an encrypted tunnel for their data to travel through. This data gets scrambled into code, making it unreadable to anyone without the encryption key. Once the data reaches the server, it is decrypted using the server's private key and then sent back to the site you're trying to connect with, along with a new IP address.

The security of this encryption process depends on the protocol used to establish the connection. A VPN service can only ensure security and peace of mind if it uses a strong protocol, as it is the foundation that keeps a VPN operational.

How a VPN Protects Your IP Address

In addition to encrypting your data, a VPN masks your IP address from the public internet, thereby concealing your identity. When you connect to the VPN server, it not only secures your data but also assigns you a new IP address that hides your real one. This new IP address can be a shared IP, which groups multiple users into a single IP address, making individual activity hard to trace. Alternatively, it may match the IP address of the VPN server, and with multiple servers worldwide, you have many IP addresses to choose from. You can configure these settings in your VPN client according to your needs.

By hiding your IP address, a VPN also spoofs your location. This is useful for bypassing content blocks and firewalls that rely on your IP to enforce restrictions. IP masking also protects against doxing (the exposure of private information) and DDoS attacks (distributed denial of service attacks). If your real IP address is hidden, attackers can't target you.

How Secure is a VPN?

Even with the strongest protocols, a VPN cannot provide absolute security. For instance, it doesn't protect against viruses, and although a VPN can prevent advertisers from targeting you based on your cookies, it cannot block the cookies themselves. Security flaws, bugs, and other vulnerabilities may still arise, which is why it's crucial to keep your software up to date. Less reputable VPN providers might log your browsing activity and use the data for

advertising purposes. Moreover, while top providers offer high levels of encryption and IP masking, ISPs and other third parties are constantly improving their tracking methods.

Despite these potential issues, a VPN still offers a more secure and flexible online experience compared to not using one. If you want to enhance your online privacy, using a VPN is essential. With the powerful combination of strong encryption and IP masking, a VPN can effectively meet your protection needs.

How to Choose the Right VPN

- **Security Features:** Look for strong encryption (like AES-256) and advanced security protocols (like OpenVPN or WireGuard).
- **Server Locations:** Ensure the VPN offers a wide range of server locations for flexibility.
- **Speed:** Some VPNs slow down your connection. Choose one known for minimal speed loss.
- **No-Log Policy:** A reliable VPN won't store your browsing data.
- **Ease of Use:** The app should be user-friendly and available for multiple devices.
- **Cost:** Free VPNs may compromise your data. Opt for a paid, reputable service.

Common Misconceptions About VPNs

- **"VPNs are only for tech experts."**- Modern VPN apps are user-friendly and require no technical skills to use.
- **"VPNs make you completely anonymous."**- While they enhance privacy, no tool can guarantee 100% anonymity.
- **"Free VPNs are just as good."**- Free VPNs often come with limited features, slower speeds & potential data security risks.

How to Get Started with a VPN

1. **Choose a VPN Service:** Research and select a reputable provider.
2. **Download the App:** Install the VPN on your device (phone, laptop, tablet, etc.).
3. **Sign Up:** Create an account and choose a subscription plan.
4. **Connect:** Open the app, choose a server location, and click "Connect."

When Should You Use a VPN?

- While shopping or banking online.
- When connected to public Wi-Fi.
- For streaming or gaming to bypass restrictions.
- While working remotely to protect sensitive business data.

Conclusion

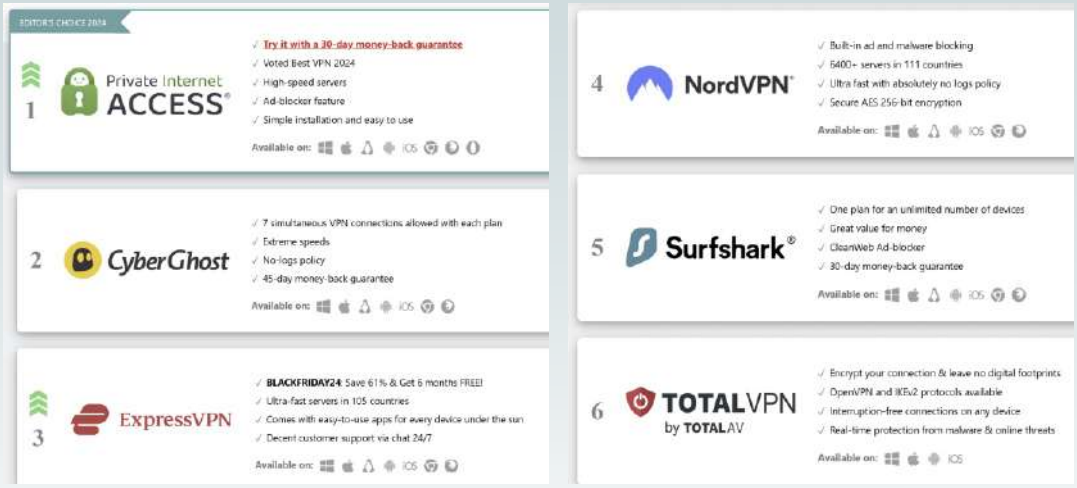
A VPN is a simple yet powerful tool that protects your online privacy, secures your data, and enhances your internet experience. Whether you're a casual browser or a business professional, investing in a reliable VPN is a smart decision in today's digital age.

By following this guide, you'll be well-equipped to understand and use VPNs to make your online activities safer and more private.

I will stop here.

Some of the top VPNS today are:

Name	Type	Connection method	Use Case
Remote access VPN (also known as client-to-site VPN)	Home	Connect to a private network or third-party server via SSL/TSL	For remote workers who need access to company files and resources over a private connection, or for users who wish to browse the public Internet over an encrypted connection
Site-to-site VPN	Private	Network connects to another network via LAN, WAN	For large organizations that need to link their internal networks across multiple sites in different locations, while maintaining a secure connection
VPN applications	Mobile	Connect to a private network via VPN app on mobile or smartphone device	For mobile users who wish to take advantage of the benefits of a VPN while on the go, or while experiencing an unstable Internet connection



I use **express VPN**

For more details contact me on 98200 91852 or best join **my techdoc group by Dr Alok Modi** at the following QR code:

List of AMC work (Social service cell)

Dr S N Agarwal
Past President of AMC

I express and extend my sincere heartfelt gratitude to the President AMC DrVivek Dwivedi with entire team of Association of Medical Consultants, Mumbai for giving me the opportunity to contribute Social service through your esteemed platform for AMC. It has been an enriching experience to be part of Initiatives aimed at improving community health and well-being by Vaccination, investigation,medical camp,blood donation camp,old home visits,school health checkup with education and above all -Nursing Training Program to name some as the list is long. We have also taken initiatives aimed at improving community health and well-beingand education to health care worker, organ donation awareness, blood donation and diabetes prevention.

The support and guidance provided by AMC have been Invaluable & I truly appreciate the effort taken by consultant of my area Mira - Bhayandar and AMC team who have demonstrated exceptional professionalism, expertise and kindness in their interaction with social service cell. The experience has deepened my commitment to service society through AMC has inspired me to continue working towards the betterment of Healthcare access and awareness

Once again I am deeply thankful for AMC Team trust and allowing me to be a part of this social service (Noble cause). I look forward to continuing my association with AMC in future

स्वस्थ रहें, मस्त रहे.

- 05-04-2024 : Medical camp at UttanGorai
- 13-04-2024 : menopause women examination and education
- 06-05-2024 : Distribution of study materials like books,pen,shoes to Orphan children
- 20-05-2024: Arrange accommodation for Police during state election
- 23-05-2024 : Vaccination to pregnant ladies
- 26-05-2024 : Nurses Training Program at Ridhi Vinayak Hospital (Nalasopara)
- 07-06-2024 : ANC class for High risk pregnancy
- 14-06-2024 : How to prepare abdomen before surgery for Nurses
- 20-06-2024 : CPR Training at Water-kingdom
- 22nd & 23rd June 2024 : Kolkata FOGSI Award for Nurses Training Program
- 29-06-2024 : BMD camp at Bhayander
- Piles & Fissures camp (Diagnostic and surgical) organized by DrNiranjan Agarwal at Bhayander

- 01-07-2024 : Lifetime award by Wockhardt hospital to me on Doctors day
- 07-07-2024 : Doctors day celebration and Blood donation camp
- 10th to 13th July 24 : School Sex education
- 27-07-2024 : BMD camp at Borivali East
- 03-08-2024 : Hb camp & Blood donation camp
- 03-08-2024 : Nurses Training Program on Lactation
- 08-08-2024 : Awareness camp during Breast feeding week for public & Doctors
- 04-09-2024 : Teacher's Day celebration
- 25-09-2024 : Male Sexual Problem lecture for General Practioners
- 29-09-2024 : Nurses Training Program in Wockhardt hospital
- 27-10-2024 : Thyroid camp at Waterkingdom

24-12-2024 : Thyroid camp at Bhayander

- 3rd to 10th Jan 2025 : School Health checkup,School education with BMA and in 3 Municipal school
- 07-01-2025 : Blood Donation Camp
- 12-01-2025 : Medical camp and ambulance service
- Marathon at Borivali 5:30 am
- 15-01-2025 : Blanket Distribution to old age home with mankind pharma
- 23-01-2025 : Nurses Training Program at GCC club
- 26-01-2025 : Blood Donation camp
- 08-02-2025 : BMD camp at Gorai

Nazareth school education, Municipal school of Mira-Bhayandar, Ramratan Vidyamandir, Seven eleven school; School sex education time to time given by **Dr. Smitha Moorty and Dhanjay Gambhir**

'AMCON oration by Padma Vibhushan Dr Anil Kakodkar'

MMC Cell Update

Dr Sujata Rao
Managing Trustee
Chairman MMC Cell

The Maharashtra Medical Council is a quasi-judicial body that regulates the medical profession and holds the power to suspend or revoke doctors' license. It regulates medical education and ethics for registered doctors in Maharashtra and processes approximately 9,000 new registrations annually.

The 18-member MMC has been without a committee since August 7, 2022, when its previous term expired. Dr Pallavi Saple, Dean of Sir JJ Group of Hospitals, was appointed as administrator for a year following the dissolution. After her term ended on October 9, 2023, the additional charge was handed over to Dr Dilip Mhaiskar, director of the Directorate of Medical Education and Research (DMER). Subsequently, Dr VinkyRughwani, former MMC vice president, was appointed as administrator.

Since the council was dissolved, there has been a backlog of medical negligence cases and delays in routine functions. Currently, nearly 500 medical negligence cases are pending hearings.The delay in Continuing Medical Education (CME) approvals has also caused logistical challenges, with organisers often receiving permissions just 24-48 hours before events. Additionally, doctors seeking no-objection certificates to relocate to other states or countries have faced delays.

Since the Govt of Maharashtra Notification to declare Election to the MMC on 17th January 2025 has been published, the Election process & the Council is facing severe scrutiny over its electoral procedures. The Association of Medical Consultants was the only Doctors' body, which has pointed out several irregularities to the Registrar, MMC. We have not received any reply to our queries as yet.

Following are some glaring inadequacies in the electoral process

1) The nomination forms were not available, almost for 14 days following the notification.
2) There was a tedious process of physical application to secure the Nomination form from the Registrar, Maharashtra Medical Council office, located at Anand Complex, 1st Floor, Sane Guruji Marg, Arthur Road Naka, Chinchpokhli (West), Mumbai 400 011.
3) Completed nomination papers were be submitted to the Returning Officer at the office of the Registrar, Maharashtra State Dental Council, 3rd Floor, Govt. Dental College & Hospital, St. George

Hospital Compound, Near CSMT Railway Station,Fort, Mumbai400 001.

4) The Elections are being held on a working day, i.e Thursday only at district headquarters.

In this digitally advanced era, the Council has relegated a significant election into a mockery by adopting a colonial approach towards the medical community. This election procedure does not promise a fair process of selection, voting or representation to the only regulatory body for the Doctors of the state. It has already evoked a number of legal petitions questioning the transparency & intent of the hurried manner of holding elections after a delay of almost 2.5 years!

The Managing Committee of the Association of Medical Consultants Mumbai created a nine member committee to deliberate on the best possible strategy to project their representation to the MMC. The committee had a first & foremost principle of promoting a United front of the medical community in the Elections and hence reached out its hand of collaboration with the IMA. Since we did not get any positive reply, the next strategy to align with like-minded organisation was adopted. In all the meetings of the committee as well as the Managing Committee, the focus was to reach out to the interior regions of Maharashtra and get appropriate candidates. It was hence unanimously decided that the secretary of FAMCI (Federation of AMCs of India), Dr Nilesh Naphade from Ratnagiri would be an ideal candidate, since he is well known in his region, has a reliable legal knowledge & has an endorsement from his Specialty bodies aswell.

Dr Nilesh Naphade is one of the few Doctors to have a dual Specialty postgraduate training & practices Radiology & Anaesthesiology since 20+ years.

The Federation of AMCs of India & AMC Mumbai firmly believes that it is important to have a single genuine representation in the Medical Council. It is guided by the thought process that it is better to continue our illustrious legacy of helping individual Doctors facing hardships due to haphazard litigations and handling of patient's complaints by the Council. Hence there was no knee jerk decisions taken by the nine members community lead by the Chairperson MMC Cell, to be restricted to select from a list of individual applicants who did not fulfil our well selected criteria.

We urge you to spare your valuable time on 3 April 2025 bet 8 am to 5 pm to visit your polling centre and cast your vote for FAMCI & AMC Candidate, Dr Nilesh Naphade, in order to ensure a fair representation of AMC Medicolegal expertise, with a promise to create needed reforms in the Maharashtra Medical Council.

Bombay HC urged to review Maharashtra medical council election notice over voter accessibility concerns https://timesofindia.indiatimes.com/city/mumbai/bombay-hc-urged-to-review-maharashtra-medical-council-election-notice-over-voter-accessibility-concerns/articleshow/118977530.cms

Digital Healthcare and The DPDP (Digital Personal Data Protection) Draft Rules, 2025

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Introduction

The healthcare ecosystem in India is evolving with rapid advancement of digital technologies and increasingly demanding patient needs. Telemedicine platforms and technologies such as virtual consultancy, video conferencing, and remote patient monitoring are enhancing patient access to care. Mobile health technologies are elevating patient engagement and self-care, and Artificial Intelligence is being deployed to improve diagnostic accuracy, patient care and operational efficiency. However, the widespread use of technologies is fraught with its own challenges. There is lack of integration between software applications, databases and devices used by public and private healthcare providers. Interoperability of data is another challenge. Because in healthcare, the ability to exchange and interpret data from various systems and devices is critical, as patient data needs to be shared between different healthcare providers in both public and private health domains. The new draft Rules 2025 is introduced to address the privacy concerns.

The evolving digital healthcare in India

The major stakeholders in healthcare are patients/citizens, the government, healthcare providers, healthcare administrators, health insurers and payers, and the healthcare industry, which creates a dynamic health ecosystem. Engaging all the stake holders and addressing their needs in the health policy process has been a daunting task for India, like any other low-income country. Serving the vast rural population and the growing burden of non-communicable diseases continues to be a major challenge for the country. There has been an acute shortage of trained professionals with 0.9 doctor per 1000 population, limited health insurance coverage and inadequate primary, secondary and tertiary healthcare infrastructure. Only digital health can address these issues and provide solutions to make healthcare affordable and accessible. In fact, digital transformation entails integrating digital technologies in all aspects of healthcare. It involves a cultural shift in an array of stakeholders as well as regulatory changes.

Digital India program by Government of India is a step in this direction, it is spearheading various initiatives like Ayushman Bharat Digital Mission, Aarogya Setu and E Hospital. The development of

Adhar linked with UPI transformed the banking sector, in a similar fashion the EHR-electronic health record is expected to transform the healthcare access. The virtual care, remote patient monitoring & m-health are driving digital transformation. There are a range of innovations in wellness and fitness area with smart wearables, AR/VR games and wellness apps. The enterprise solutions are being introduced such as EHS, enabling technologies of Big Data, blockchain, IoT and Cloud Technologies. The innovative digital technologies are improving health outcomes from prevention to treatment of diseases and therapeutics. Providers, users, and patients can use digital healthcare to improve patient care, improve operational efficiency and Improve compliance. Providing affordable and accessible healthcare in the country, will certainly help accelerate our journey towards the goal of UHC (Universal Health Coverage) for all.

Nevertheless, the adoption of digital health technologies faces many structural, organisational and legal barriers. Changes in the demographic profile and increasing burden of disease of an expanding population weighs heavily on the existing healthcare infrastructure in India Providing healthcare access in remote areas is a challenge; there is insufficient investment in public health facilities to meet the demand of a growing population; there is resistance to utilising innovative digital technologies by various stakeholders; there is a challenge of affordability and accessibility; there is a lack of transparency and standardisation and there is the challenge of the presence of multiple stakeholders in the health ecosystem. Besides barriers mainly associated with limited technological and medical infrastructure, data privacy in healthcare has been a serious concern.

Data privacy in digital healthcare

Healthcare is an extremely information - intensive industry. The unique nature of the industry necessitates the collection, processing, storage, retrieval, and transfer of information, most of which is highly sensitive in nature. When it comes to digital healthcare, privacy issues are gaining huge significance because of the increasing collection of individuals' health data through the Internet of Medical Things (IoMT) and the growth of wearable devices market. This is where the tackling of the inherent problem of the misuse of information, disclosure of information, and the risk of breaches lies. As India does not have a stand-alone personal data protection law, privacy protections are available through a mix of statutes, rules and guidelines.

The legal safeguard proposed by the new Digital Personal Data Protection Rules 2025, to facilitate implementation of the Digital Personal Data Protection Act, 2023 (DPDP Act) is a landmark shift in India's approach to data privacy since it envisions a responsible data management. Moreover, the DPDP Act and the Rules 2025, propose a 'rights- based' framework that prioritises access to quality healthcare, user control over data, and the recognition of the rights to privacy and informed consent.

...continued on page no. 53

Few Highlights of AMCON

Shri Subodh Tiwari, **Hon. Secretary**
Indian Yoga Association and CEO-
Kaivalyadhama, Lonavala

Address by Additional Solicitor
Gen Solicitor General of India
Senior *Advocate Raja Thakare*

Advocate Jamshed Mistry
Advocate Rui Rodrigues
"Challenges of the Healing Hands!
Securing the Doctor's future"

Shri Sudarshan Shetty
felicitation at AMCON

Professional Indemnity & Errors and Omissions Scheme

Protecting Medical Professionals with The Oriental Insurance Co. Ltd.

Why Professional Indemnity Insurance?

Medical professionals require specialized insurance to safeguard themselves from financial and legal consequences in cases of negligence, malpractice or errors. Our Professional Indemnity Insurance Scheme provides essential coverage to ensure peace of mind.

Why Errors and Omissions (E&O) Insurance Scheme?

E&O insurance Scheme is designed to protect healthcare professionals and medical establishments from legal claims due to mistakes, negligence or failure to meet professional standards in patient care.

Why choose AMC?

Comprehensive Coverage & Protection

- Extensive professional indemnity insurance for doctors, covering legal and financial liabilities
- Protection against negligence, malpractice, and medical errors
- Nationwide coverage across India with worldwide jurisdiction
- Covers civil cases, including:
  - Consumer Forums
  - State Medical Councils
  - Medical Council of India
  - Human Rights Commissions
  - Competition Commission of India (CCI)
  - Police Inquiries
- Defense cost coverage for criminal cases related to medical accidents, operational mishaps and patient deaths

Exceptional Service & AMC Support

- Over 30 years of expertise in medico-legal insurance
- 100% legal assistance and in-house claims support at no additional cost
- Personalized guidance through AMC's dedicated medico-legal cell
- 1:1 claim ratio ensuring fair settlements and prompt assistance

Legal Assistance & Claims Handling

- Coverage includes legal fees and pre-litigation expenses
- Cashless service for advocate payments
- Travel expenses (airfare + accommodation) covered for National Commission case hearings
- Expert legal support from AMC Medico-Legal Advocates instead of insurer-appointed lawyers
- Guidance from AMC Medico-Legal Cell for out-of-court settlements
- Run-Off Cover available for retiring doctors and closing medical establishments

Policy Features & Exclusive Benefits

- Coverage extends to both qualified and unqualified medical staff
- Protection for medical establishments, including hospitals and clinics
- Special coverage (at an additional premium) for high-risk procedures such as:
  - Cosmetic Surgery
  - Lasik Surgery
  - Radioactive Treatment
- Retroactive date coverage included for past liabilities
- Policy renewal within 6 months of expiry allows restoration of the retroactive date with an additional 25% fee
- Cashless claim settlements ensure a seamless reimbursement process

Protect Your Practice, Empower Your Peace of Mind – Secure Your Future with AMC's Professional Indemnity Insurance Scheme today!

Contact your agent to know more!